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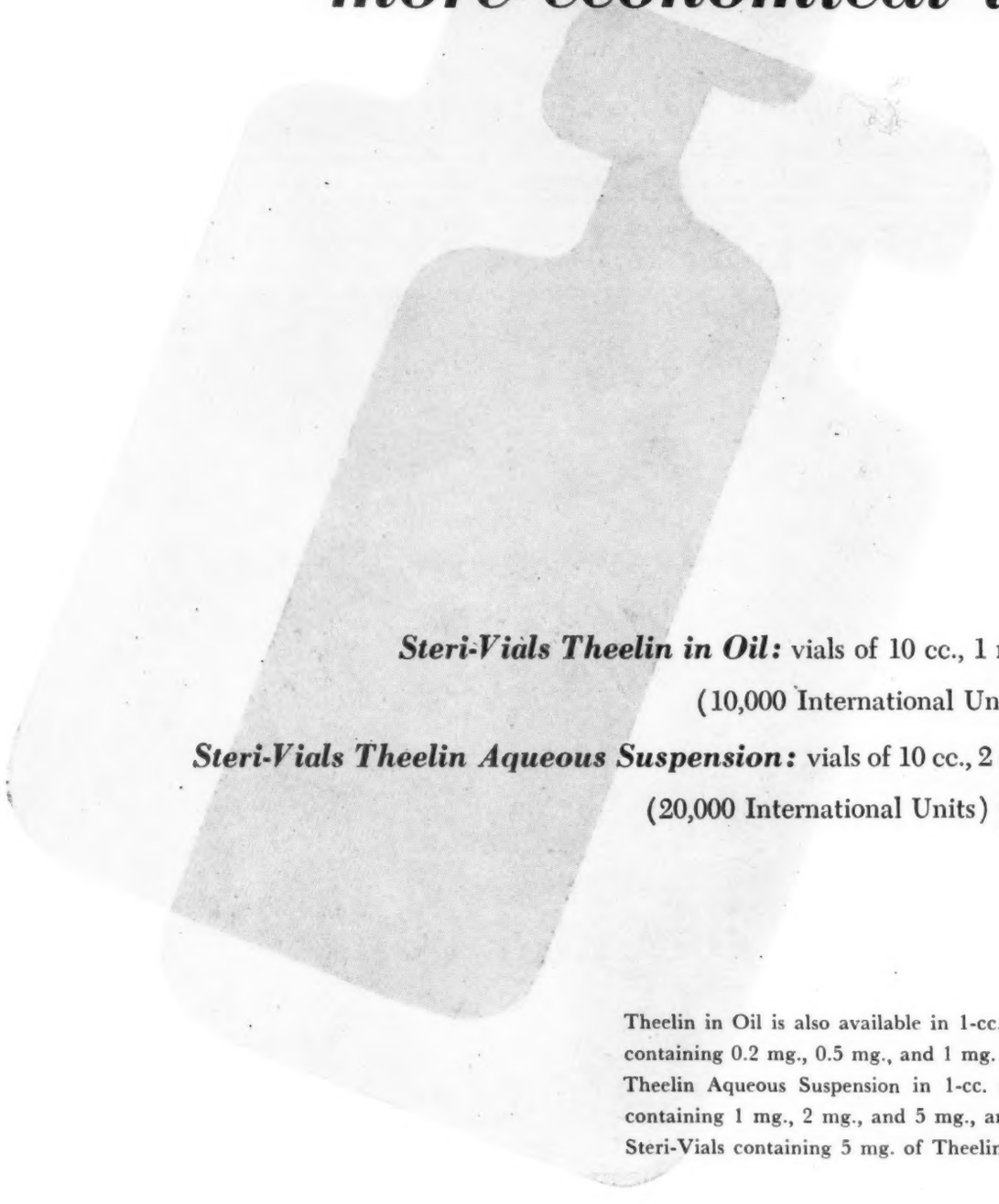

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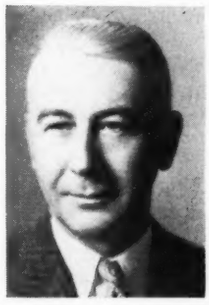

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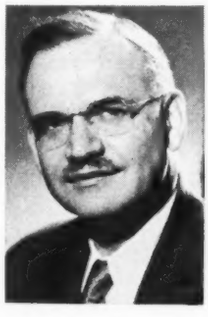

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PROCUREMENT AND ASSIGNMENT

Calling Up Reserve Officers

A new set of priorities was issued by the Defense Department in late September, 1950. Reservists are to be called in the following order:

First Priority: Medical reserve officers who received all or part of their professional education in ASTP or V-12 and who have had no military service as medical officers.

Second Priority: Those who participated in ASTP or V-12 programs and who have had subsequent military service, with those having the least service to be called first.

Third Priority: All other reserve officers, also to be called in relation to their past military service.

It was emphasized that reserves with special skills may be called in spite of these categories.

Substantially, all of the first group will be ordered to active duty before calls are made for other classifications. This priority system does not apply to physicians in organized reserve units; they will be called with their units. Please note that *this system applies to reserves only and not to draft registrants.* No more veterans will be called than are absolutely essential. This is possible, now that the doctor-draft law is on the books as the Army has decided it can hold back on its medical staffing until younger, non-veteran doctors join the reserves as the result of the draft pressure. Commanders have been urged to use non-veterans if they are available, although they are free to call on older reservists to fill their *second* quota.

Navy to Call Reserve Medical Officers

The Department of the Navy was directed on September 29 to order to active duty enough V-12 trained Navy Reserve medical officers without prior service to meet requirements for all three military departments. These medical officers will be assigned to duty with the Army and Air Force to meet their needs. The first increment is required to be on duty at designated stations by October 15, 1950.

The first priority group includes medical reserve officers, other than members of Organized Reserve units, who participated in the ASTP or V-12 training programs of the Army and Navy and who have had no subsequent military service as medical officers.

The second priority group includes ASTP and V-12 participants who served as military medical officers after completion of training.

The third and final priority group includes all other reservists.

Of the 1429 Navy Reserve medical officers in priority group one, some 1350 are available for immediate call to active duty. The remainder are members of Organized Reserve units not subject to call at this time.

Draft Registration

Only the first group or priority must register now (those M.D.'s educated by government and those deferred to study medicine). PLEASE ADVISE YOUR MEMBERSHIP AT ONCE, BY LETTER, THAT THESE M.D.'s SHOULD GET RESERVE COMMISSIONS NOW AND NOT BE FORCED TO BE INDUCTED INTO THE ARMY AS A *PRIVATE WITHOUT BONUS.*

It is definitely to the advantage of the individual doctor of medicine (and the entire medical profession) to co-operate. The Defense Department is being most fair in seeking the advice of the Office of Medical Services (and of state and county Medical Procurement Advisory Committees) to control the flow of medical officers into the three military services. Seeking the advice of civilian groups is an innovation in military circles, and this consultation system must be encouraged and maintained by the active, enthusiastic co-operation of county and state medical societies.

No Total Registration of Doctors Now

Please reassure your membership that *not all M.D.'s up to age fifty-one are to be registered now;* they will register in groups according to priorities listed in Public Law 779, 81st Congress. The registration at this time is limited to those in the first

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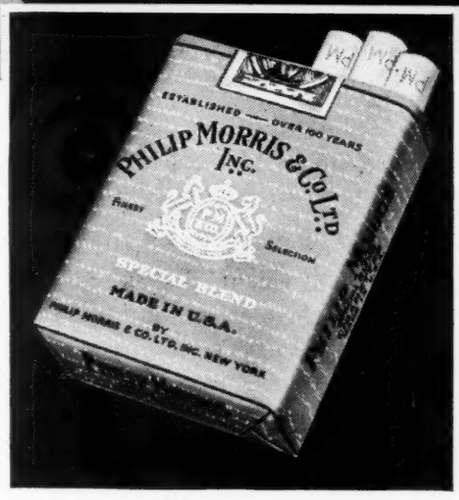

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No Total Registration of Doctors Now

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priority, as listed above. Those in the first priority who do not volunteeer can expect to be drafted in the very near future.

Medical Procurement Advisory Committee

The MSMS Council has appointed a Medical Procurement Advisory Committee, representative of all geographical areas of Michigan. This committee is available for advice in questions of procurement and may be reached by addressing the Chairman, c/o 2020 Olds Tower, Lansing 8, Michigan.

The Council recommends that every county medical society appoint a local Medical Procurement Advisory Committee from which the state Medical Procurement Advisory Committee may obtain information and advice when necessary. The MSMS Medical Procurement Advisory Committee recommends that the county committee be composed of its president, its secretary, and its immediate past president. Please certify the personnel of the county M.P.A. Committee to the MSMS Executive Office in Lansing as soon as possible.

You will be kept advised of developments and we sincerely trust that you transmit this and all future information without delay to your membership. This will eliminate much confusion and obviate a great deal of correspondence with Selective Service and with the military services (which are now swamped with thousands of telegrams and letters of inquiry).

National Guard Medical Men to Receive Extra Pay

National Guard medical officers inducted into the Army of the U.S. will receive the $100 extra monthly pay under legislation approved by the President, September 21. The bonus payment is currently being made to Doctors volunteering for service in the Armed Forces.

Procurement and Assignment for Michigan

Grover C. Penberthy, M.D., Detroit, was appointed Chairman of Procurement and Assignment for Michigan by the MSMS Council at its September 22 meeting in Detroit.

H. H. Stryker, M.D., Kalamazoo, was chosen as First Vice Chairman and John R. Rodger, M.D., Bellaire, was selected as Second Vice Chairman of Procurement and Assignment for this State.

Brief of Doctor-Draft Law

Doctor-draft law recently enacted by Congress (Public Law No. 779) amends the Selective Service Act of 1948 and contains the following provisions:

1. *Authorizes the President to require special registration of and to make special induction calls for male physicians,* dentists, pharmacists, osteopaths, optometrists and veterinarians.
2. *Sets age limit for registration at 50;* provides none may be inducted after reaching his 51st birthday; specifies any inducted shall serve a maximum of 21 months . . . as medical officer if acceptable to military.
3. Provides for the following four priority groups of registrants, and that they shall be inducted, if necessary, in the following order:
   (a) Those deferred from military duty during World War II, including ASTP and V-12 doctors, to complete their professional training and who subsequently had less than 90 days active military duty or Public Health Service duty.
   (b) Those in the foregoing category who had more than 90 days but less than 21 months of active military or Public Health Service duty.
   (c) Others within the age limitation who did not have active military or Public Health Service duty subsequent to Sept. 16, 1940.
   (d) Those not in categories (a) and (b) who had some military or Public Health Service duty subsequent to September 16, 1940, under a procedure whereby those who served the least number of months would be called ahead of those who served a greater period of time.
4. Exempts from registration and induction physicians who are members of reserve components of the armed forces, as they are already subject to direct call from their component military service.
5. Endorses annual deferment from active duty of premedical, predental, preosteopathic and preveterinary students in numbers at least equal to the numbers of such students now in attendance.
6. Provides for deferment of covered registrants whose deferment is found to be equitable and in the national interest, taking into consideration length of previous service, extent of participation in the ASTP or V-12 programs, reasons of hardship or dependency, and the maintenance of the national health, safety, or interest.
7. Provides for $100 a month extra pay for physicians who volunteer for active service and for all reserve officers, regardless of whether they volunteer for or are ordered to active duty.
8. Authorizes the establishment of a National Advisory Committee to Selective Service to co-ordinate the work of local and state advisory Committees on the selection of needed medical personnel.

CIVILIAN DEFENSE

To the Council of the
Michigan State Medical Society
2020 Olds Tower
Lansing, Michigan
Gentlemen:

As your representative I attended the meeting of the Regional Council on National Emergency Medical Service held at the Sheraton Hotel in Chicago on September 10, 1950.

I enclose a list of those present from which you will note that our Society was poorly represented both in quantity and quality. Several delegations came complete with stenographer and took home complete transcripts of proceedings.

Reports from states as to present state of preparation for Civil Defense may be summarized as follows.

Ten states have no legislation or are operating under old laws. Indiana and Ohio have new legislation for Civil Defense.

In practically all states a Civil Defense Director has been appointed.

In about half the states the duties of Civil Defense and Procurement and Assignment are merged in some way in one committee. In the other half they are separate.

Apparently calls for reserve officers are being cleared by the Army with Procurement and Assignment boards throughout the Region. Neither the Air Force nor the Navy are making a practice of calling inactive reservists involuntarily.

The state of Tennessee has established three Mobile Radiologic centers for radiologic detection service in event of disaster.

In general, the state of preparation throughout the region parallels our own. Perhaps Indiana and Ohio are more advanced.

The Council stresses the mailing of their questionnaire to all physicians both from a Civil Defense standpoint and from a procurement standpoint. Since they are so insistent, I now recommend, that it be mailed to all physicians. I previously thought otherwise. I also recommend that the plan used in Iowa be duplicated. This plan marks the envelope "Military Information" and the questionnaire bears this notation: "If this questionnaire is not returned it will be assumed that the recipient will volunteer for military service." It is said that the return of questionnaires is reaching high percentages.

I enclose a release from the Department of Defense dated September 9, 1950, dealing with priorities in calling Dental and Medical Reservists. In this connection I asked the question of a representative of the Secretary of Defense as to the number of individuals with "exceptional qualifications" who would be called and got the impression that it would be relatively small but definitely tangible.

Doctor George M. Lyon spoke of organization of state and local units. He and all other speakers emphasized that this plan must be set up on a state or regional basis. Local organizations must be capable of local use but must also be mobile. This follows the previous conception on which all of our plans have been developed.

He strongly suggests doctors be indoctrinated in realistic organizational phases of this problem, teaching them what to expect in disaster. This follows previous recommendations made to you by your Emergency Medical Service Committee.

Doctor Lyon estimates casualties that will survive the first day of a bombing comparable to Hiroshima at 80,000. On this basis he represents blood requirements at 240,000 pints.

Some explanation was made of the proposed "dry run" to be held in Chicago and the similar exercises already held in Washington and Seattle.

Red Cross representative says his organization will aid in blood procurement, feeding and shelter, and in education of first aid personnel. The N.S.R.B. wants 20,000,000 people trained in first aid.

It is estimated by the Red Cross that twenty-five Auxiliary Nursing Personnel will be required for each nurse.

Major General Armstrong emphasized that the Air Force has called no reserves having supplied itself with enough volunteers. Brigadier General Schictenberg, of Office Secretary of Defense, emphasized that there would have to be reservists called to duty before draft of doctors, et cetera, becomes productive. How many depends on how many volunteers from A.S.T.P. and V-12 groups.

Rear Admiral Agnew of the Navy states they have called for most part only officers of organized reserve who have been drawing pay in their present peacetime assignments.

Colonel Simmons of Surgeon General's office of the Army stated they were short 750 medical officers before Korea. They have called in reserves and have at present about 150 applications from A.S.T.P. men. They feel the volunteer situation is brighter. No doctor can volunteer after he has been called by the draft board.

Colonel Eaves of Office of Selective Service reported that it would be about ninety days after draft of doctors is put into effect before the first would be in uniform.

All services emphasized that as of the present the only source of medical man power is the Reservist and the Volunteer.

General Armstrong strongly urged the P and A machinery be set in operation, because armed services have no way of knowing who is essential to the civilian community.

Respectfully submitted,

H. F. Becker, M.D.

GENERAL GEORGE C. MARSHALL, SECRETARY OF DEFENSE, ACTS

The Navy was ordered to assign V-12 reservists to active duty with Army.

The Army will release some of World War II reserves after three to four months.

Two developments have drastically changed the military medical situation. The net result is that far fewer World War II reserves than anticipated will be called to active duty in the next few months, and that many of

(Continued on Page 1260)

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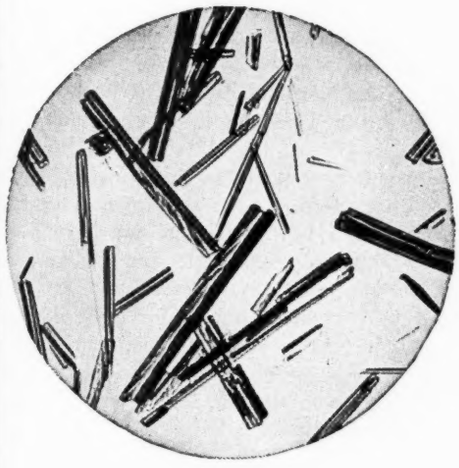

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GENERAL GEORGE C. MARSHALL, SECRETARY OF DEFENSE, ACTS

(Continued from Page 1258)

those currently on active duty or yet to be called on mandatory orders will be required to serve only three or four months, rather than twenty-one months.

The most important development came in a directive from the new Secretary of Defense, General George C. Marshall. He ordered the Navy to call up enough of its V-12 reserves to meet the immediate requirements of all three services, with the first 235 to be on duty with the Army by October 15.

Navy's total of 1,350 V-12 reservists who have not served on active duty should be ample to meet immediate demands. Most transferred V-12's will go to Army, which already has a call in for a total of 570. Air Force, with a growing medical reserve roll, probably will need few if any Navy men.

Even before Secretary Marshall announced his decision, Army had decided on an arrangement to cut down active duty terms of World War II reservists from twenty-one months to an average of three or four months. The plan calls for using veterans only until non-veteran replacements can be processed into uniform. Until Secretary Marshall's order, Army could plan on only two sources of non-veterans—volunteers and the doctor-draft. Now, with Navy told to supply the men, Army's plan can be implemented immediately.

From now on, the general policy will be to return veteran reservists to civilian life as fast as possible, with the hope that their active-duty tours will not exceed four months. This will apply specifically to men called without their consent, but volunteers with World War II service will also be given consideration.

Army will not be able to apply its new policy uniformly to all reserve officers. Some members from at least two groups will not benefit from the plan: (1) Certain senior officer specialists in various categories, whose professional skills make them difficult to replace. (2) Certain senior command and staff officers whose military background makes them difficult to replace.

Navy has not indicated whether it will attempt to follow the Army's policy of reducing the service of World War II medical veterans. It already has a number of these men on duty, called up on mandatory orders before it started using its V-12 reserves. However, Navy officials have been concerned with the problem and would like to find some way of replacing veterans with non-veterans.

This help from Navy won't meet all Army's requirements during the next two or three months. While waiting for the doctor-draft to produce medical officers, Army plans to call up a total of 500 reserves, mostly with World War II service. However, 350 of them can look forward to returning to their practice after three or four months, or as soon as the draft makes replacements available.

Of this new group to be called to active duty, 130 already have received orders. Another group of 220, members of organized military units, will be alerted when their units are called, but generally will be allowed to remain in civilian life until the units are ready to move. The remaining 150 are specialists and senior officers with command responsibilities. This group will not come under the new "four-month" policy, but will remain on duty as long as needed.

Army is understood to be ready with a request for about 900 physicians when the doctor-draft law goes into operation. All would be from the first priority—men who received all or part of their education either as ASTP's or V-12's and have not served on active duty. It will be these men, reporting for duty probably by the first of the year, who will make possible the release of World War II reservists.

ARMY TO REOPEN THREE GENERAL HOSPITALS

Representative Carl Vinson, chairman of the House Armed Services Committee, has announced that Army will reopen three general hospitals ordered closed last spring and enlarge the capacity of nine station hospitals. It was an Armed Services subcommittee, under chairmanship of Representative L. Mendel Rivers, which opposed the original closing orders, but was overruled by Defense Department. General hospitals affected are Valley Forge, Pa.; Murphy General, Waltham, Mass.; and Percy Jones General, Battle Creek, Mich. Bed capacity of the three will total almost 5,000. According to Mr. Vinson, action was taken in view of an increase in the rate of casualties to be flown back from Korea. To date slightly more than 3,000 have been returned; by December 1 it is estimated the total will reach about 11,500. Shortly after Mr. Vinson made the above announcement, Defense Department's Office of Medical Services (Dr. Meiling) issued a fact sheet, reviewing the military hospital situation from the start of the Korean war. It noted that between July 1 and October 1 operating capacity had been increased by 12,416 beds for a total of 49,408 (not including capacity of the hospitals to be reopened). According to the fact sheet, 20,908 operating beds were vacant at the time Mr. Vinson announced the hospital expansion program. Dr. Meiling's report also said that hospitals already activated could provide an additional 62,592 mobilization beds "as the need arises and personnel to staff them becomes available."

WHO IS IN THE RESERVES? SURGEONS GENERAL GIVE DEFINITIONS

Inquiries to the Washington Office of AMA indicate uncertainty on the part of some physicians as to whether they actually are in the military reserves at this time, and therefore subject to call.

Because of the many laws, rules and regulations involved, only the proper military authorities can give a final answer in any particular case. The best advice this office can give is this: If the man served in the Army, and has (or thinks he might possibly have had) a reserve commission, he should contact the commander of the military district in which he resides for official determination of his status. If he served in the Navy, and is concerned about his status, he should contact the commandant of his Naval district.

At our request, the Army Surgeon General's Office

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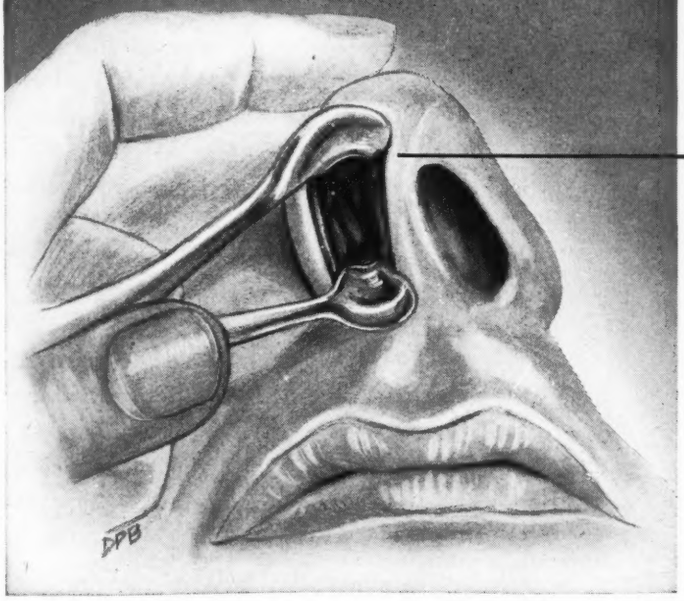
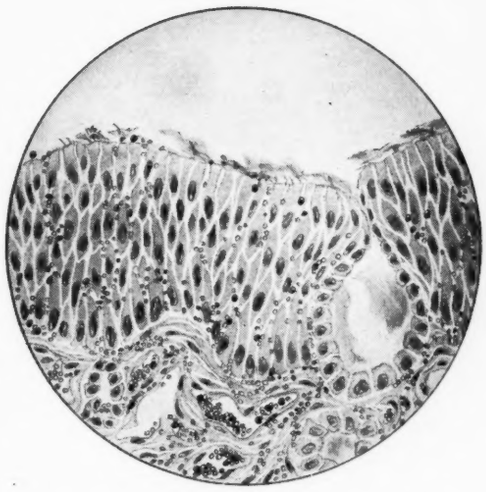
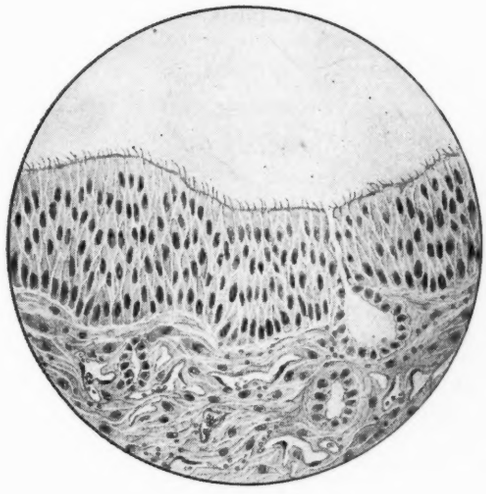
. . . sinusitis





Nasal membrane showing increased leukocytes with denudation of cilia.

Normal appearing nasal epithelium.



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GOOD NEWS FROM OREGON

On September 28, 1950, Federal Judge Claude McColloch ruled that "Oregon's organized medicine" (Oregon State Medical Association and certain physicians) have not violated the Sherman anti-trust act in their prepaid medical service plan. The Government charged that the State Medical Society, a number of county societies and several physicians, sought to monopolize the field of prepaid medical care by refusing to deal with private agencies and by disciplining physicians who did deal with them.

Judge McColloch wrote:

"I hold that the Oregon Physicians Service is not a conspiracy but rather an entirely legal and legitimate effort by the profession to meet the demands of the times for broadened medical and hospital service, eliminating the evils of privately owned concerns as well as the element of private profit."

It is most interesting to note how minor was the newspaper coverage given this long awaited decision which strikes a decisive blow against the Administration's efforts to intimidate the medical profession. This lack of fanfare contrasts markedly with the trumpeting given the initial and unfounded accusations.

HIGHLIGHTS OF THE COUNCIL MEETING

September 17 and 22, 1950

- Monthly financial reports were presented, studied, and approved by The Council.
- Report on bonds presented by Treasurer A. S Brunk, M.D., also was approved.
- An 11-month financial report of the Cancer Control Committee was presented and approved.
- The monthly report of the MSMS Rheumatic Fever Control Co-ordinator (Lean DeVel, M.D.) was read and approved, including favorable action on recommendation for a scientific talk on rheumatic fever control, at one of the regular meetings of the Wayne County Medical Society.
- Procurement and Assignment for Michigan: The appointment of Grover C. Penberthy, M.D., Detroit, Chairman, H. H. Stryker, M.D., Kalamazoo, First Vice Chairman, and J. R. Rodger, M.D., Bellaire, Second Vice Chairman, was approved.

  A Medical Procurement Advisory Committee was authorized and The Council Chairman appointed the following personnel, approved by The Council: C. I. Owen, M.D., Detroit, Chairman, C. H. Frantz, M.D., Grand Rapids, W. H. Huron, M.D., Iron Mountain, E. C. Miller, M.D., Bay City, G. C. Penberthy, M.D., Detroit, J. R. Rodger, M.D., Bellaire, H. H. Stryker, M.D., Kalamazoo, M. J. Capron, M.D., Battle Creek. The Council decreed that all correspondence and all lists of reserve officers and draftees are to be referred to the Medical Procurement Advisory Committee for processing.

  A paragraph on the new doctor draft law was ordered inserted in the Supplemental Report of The Council.

  The Secretary was authorized to notify the Presidents, Secretaries and Editors of Michigan's county medical societies re (a) calling up reserve officers; and (b) draft registration; and (c) Medical Procurement Advisory Committee functions, in the Secretary's Letter.
- The Council endorsed the principle of legislation for the enrichment of flour, following precedent set by the American Medical Association.
- D. H. Kaump, M.D., Detroit, was recommended to the Governor as a member of the Technical Committee on Health and Medical Matters in Civilian Defense, as per the appointment of President-elect, C. E. Umphrey, M.D., Detroit.
- A resolution recommending an increase in the number of medical graduates from Michigan's two medical schools, for introduction into the 1950 MSMS House of Delegates, was approved by The Council.
- Meetings of MSMS Committees during MSMS Annual Sessions and during Michigan Postgraduate Clinical Institutes: The Council instructed that MSMS Committee Chairmen be requested to hold no meetings during the MSMS Annual Session and during the Michigan Postgraduate Clinical Institute except in cases of dire emergency, because of (a) lack of meeting rooms and (b) lack of secretarial coverage.
- National Emergency Medical Service Conference, Chicago, September 10—report of H. F. Becker, M.D., Battle Creek, Chairman of MSMS Emergency Medical Service Committee. This

(Continued on Page 1264)

HIGHLIGHTS OF THE COUNCIL MEETING

(Continued from Page 1262)

report was accepted and a letter of congratulations was ordered sent to Chairman Becker.

- Committees of Michigan Department of Public Instruction: (a) at the request of the Department, the Council added three additional physicians to the Advisory Committee on Technical Schools: M. S. Ballard, M.D., Grand Rapids, W. B. Harm, M.D., Detroit, and K. H. Johnson, M.D., Lansing. (The other doctors on this Committee are O. A. Brines, M.D., and R. H. Pino, M.D., of Detroit). (b) Advisory Committee on Practical Nurse Training Project is: K. L. Crawford, M.D., Kalamazoo, and A. Hazen Price, M.D., Detroit.
- Professor W. L. Mallmann of Michigan State College was appointed to the MSMS Committee on Atomic and Allied Procedures.
- Self-testing in diabetes was approved, as per the recommendation of the Chairman of the Subcommittee on Diabetes Control of the Geriatrics Committee, and following precedent set by the American Medical Association.
- Approval was given to the request of the Michigan Epileptic Clinic, Inc., which asked approval of the Clinic's plans to establish one permanent clinic in western Michigan and a number of traveling clinics for the purpose of diagnosis and consultation of convulsive disorders on a similar basis to the Michigan Crippled Children Commission clinics.
- The Editor's Report included allocation of special numbers and covers of JMSMS for the year 1951, which recommendations were approved.
- The Supplemental Report of The Council was presented, amended in several items, and approved for reference to the MSMS House of Delegates on September 18, 1950.
- The monthly progress reports of the Legal Counsel and of the Public Relations Counsel were presented and approved.
- Committee Reports. The following Committee reports were given consideration: (a) Committee on Atomic and Allied Procedures, meeting of September 13; (b) Committee on Study of Admission Policy at University of Michigan Hospital, meeting of August 17; (c) Public Relations Committee, meeting of August 20; (d) Emergency Medical Service, meeting of August 23; (e) Special Committee on Education, meeting of August 29; (f) meeting of Ubiquitous Hosts, September 6; (g) Committee to Study Veterans Facility at Grand Rapids, meeting of September 7; (h) Geriatrics Committee, meeting of September 7.
- Four new Councilors were introduced at the meeting of September 22: Second District, R. S. Breakey, M.D., Lansing; Third District, G. W. Slagle, M.D., Battle Creek; Fifteenth District, D. Bruce Wiley, M.D., Utica; Sixteenth District, W. D. Barrett, M.D., Detroit.
- Chairman O. O. Beck, Birmingham, was thanked for his extraordinary services to The Council and to the Michigan State Medical Society throughout the years and The Council expressed the hope that he would gain even more pleasure and satisfaction in his new work as President-elect and as President of the State Society.
- Letters of appreciation were authorized to be sent to retiring Councilors Wilfrid Haughey, M.D., Battle Creek, E. A. Osius, M.D., Detroit, and P. A. Riley, M.D., Jackson for their excellent services as Councilors and for their devotion of much time and effort on behalf of the Michigan State Medical Society.
- Reorganization of The Council. R. J. Hubbell, M.D., Kalamazoo, was chosen as Chairman; William Bromme, M.D., Detroit, was elected as Vice Chairman; W. S. Jones, M.D., Menominee, was elected Chairman of the Finance Committee; F. H. Drummond, M.D., Kawkawlin, was re-elected Chairman of the Publication Committee; and J. S. DeTar, M.D., Milan, was elected Chairman of the County Societies Committee.
- President C. E. Umphrey, M.D., announced, on September 22, the appointment of Chairmen and members of the 1950-51 MSMS Committees which were approved with authority being given to the President to add or delete, at his discretion.
- Report on Conference of Youth and Children in Michigan, by Frank Van Schoick, M.D., Jackson, and R. M. Kempton, M.D., Saginaw, was read and accepted, with thanks. Others present at this Lansing conference were: H. B. Zemmer, M.D., Lapeer; and Leon DeVel, M.D., Grand Rapids.
- Official thanks were placed on the minutes of The Council to all who helped make successful the 1950 MSMS Annual Session.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, for the year 1951, sponsored by county medical societies and other physicians' groups in Michigan, follows:

January 31	Mt. Carmel Mercy Hospital Clinic Day	Detroit
February 8	Jackson County Medical Society's Clinic Day	Jackson
March 14-15-16	MICHIGAN POSTGRADUATE CLINICAL INSTITUTE	Detroit
March 17	SECOND ANNUAL MICHIGAN HEART DAY	Detroit
Spring	MSMS Postgraduate Extramural Courses	State-wide
April 3	Calhoun County Medical Society's Clinic Day	Battle Creek
April 4	SECOND MICHIGAN INDUSTRIAL HEALTH DAY	Detroit
April 18	Genesee County Medical Society's Cancer Day	Flint
April	Highland Park Physicians Club Clinic	Highland Park
May 3	Ingham County Medical Society's Clinic Day	Lansing
May	Bay County Medical Society Physical Medicine Conference	Bay City
Early June	Wayne University Alumni Annual Clinic	Detroit
June	St. Clair County Medical Society's Clinic Day	St. Clair
June	Upper Peninsula Medical Society Annual Meeting	
July 26-27	Annual Coller-Penberthy Medical-Surgical Conference (sponsored by Grand Traverse - Leelanau - Benzie County Medical Society)	Traverse City
Sept. 26-27-28	MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION	Grand Rapids
October	Second Michigan Cancer Conference	
Autumn	MSMS Postgraduate Extramural Courses	State-wide
Oct. or Nov.	American Academy of General Practice of Wayne County	Detroit
November 7	Clara Elizabeth Fund Lectures (sponsored by Genesee County Medical Society and the Clara Elizabeth Fund for Maternal Health)	Flint

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

THE AMERICAN DERMATOLOGICAL ASSOCIATION, INC.

Prize Essay Contest

The American Dermatological Association is offering a prize of three hundred dollars for the best essay submitted of original work, not previously published relative to some fundamental aspect of dermatology or syphilology. The purpose of this contest is to stimulate younger investigators to original work in these fields.

Manuscripts typed in English with double spacing as for publication, together with illustrations, charts and tables, are to be submitted in triplicate not later than February 1, 1951, and should be sent to Dr. Louis A. Brunsting, Secretary, American Dermatological Association, 102-110 Second Avenue, Southwest, Rochester, Minnesota.

Competition in this prize contest is open to scientists generally; not necessarily physicians.

The award will be made by a committee of judges selected to pass on the essays by the Research Aid Committee of the American Dermatological Association and the decision of the judges shall be final. This contest is planned as an annual one, but if in any year, at the discretion of the Research Aid Committee and judges, no paper worthy of a prize is offered, the award may be omitted.

The prize-winning candidate may be invited to present his paper before the annual meeting of the American Dermatological Association with expenses paid in addition to the three hundred dollars prize. Further information regarding this essay contest may be obtained by writing to the secretary of the American Dermatological Association.

The next annual meeting of the American Dermatological Association will be the Diamond Jubilee Observance of its founding and will be held May 23-26, 1951, at the Homestead, Hot Springs, Virginia.

OFFICE SURGERY LIBERALIZATION

Michigan Medical Service has announced a new liberalization of office surgery, effective October 1, 1950. Previous liberalizations provided for payment of surgery done in offices if item was listed on fee schedule at $20.00 or more. *Under the new liberalization, which replaces all previous ones, specific procedures done in doctors' offices or in outpatient departments of accredited hospitals will be paid for according to the fee schedule.*

Under the new liberalization, Michigan Medical Service will pay for surgical anesthesia and diagnostic x-ray services, as defined in and to the extent provided for in the certificate, (if such x-ray and anesthesia services be rendered in connection with such surgical services but not otherwise) rendered to the subscriber in the office of a doctor of medicine or in the outpatient department of a regularly accredited hospital, for the following surgical services only: biopsy via scope; thermo cautery of cervix; excision of cervical polyps; removal of nasal polyps; submucuous resection; tonsillectomy and adenoidectomy; abdominal parcentesis; circumcision; aural polyps; incision and drainage or excision of felon, carbuncle, pertonsillar

(Continued on Page 1268)

OFFICE SURGERY LIBERALIZATION

(Continued from Page 1266)

or retropharyngeal abscess; deep abscesses in other areas in accordance with depth and size.

All other terms and limitations of the certificate remain in full force and effect.

AMA COMMITTEE REPORTS ON BRITISH HEALTH SERVICE

Conclusions of the five-man AMA Committee to Study Medical Care in England make it clear that the tremendously expensive experiment carried out under the National Health Act has degraded the practice of medicine and failed to improve the health of the British people.

The Board of Trustees last spring appointed five physicians qualified in internal medicine, surgery, pediatrics, general practice and industrial health to spend not less than six weeks in England, Wales and Scotland to inquire into the workings of the National Health Act and its probable future effect.

The report of the committee, composed of Doctors Walter B. Martin of Norfolk, Va., member of the Board of Trustees, Grover C. Penberthy of Detroit, Heyworth N. Sanford of Chicago, Ulrich R. Bryner of Salt Lake City, and Carl M. Peterson of Chicago, secretary of the Council on Industrial Health, was made to the House of Delegates in San Francisco and appears in the August 19 issue of *The Journal of the American Medical Association.*

In the course of the study, the committee members interviewed officers of the British Medical Association, Ministry of Health, and Fellowship for Freedom in Medicine; staff members of medical schools and hospitals, and a large number of general practitioners and others concerned with carrying out provisions of the service.

In summary, their fine report yields these conclusions:

1. The total cost of the service has far outstripped all estimates, and there is no evidence that the peak has been passed.

2. Despite the great amount expended for medical care in England, there is no present evidence that it has in any significant way improved the health of the people, or added to their happiness. All general hospitals have long waiting lists, in some categories as long as six months to two years. Out-patient departments are bulging. Offices of general practitioners in industrial areas are overcrowded and their facilities are grossly inadequate. Funds available for medical care have been dissipated on services that are not essential and essential services have suffered.

3. The tendency of the present system is to degrade the general practitioner to the level of a clerk or a guidepost to the specialist.

4. The service has produced a greater inequality of distribution of doctors, in proportion to population, and has diluted the quality of medicine.

5. It has added nothing to preventive medicine, but has disrupted public health work and produced serious problems in tuberculosis control and preventive dentistry.

6. It has created an almost complete autocratic control of medicine through concentration of financial power in the central government and the authority given the Minister of Health to govern by directions having the weight of law.

7. Abuses of the service are evident everywhere and must lead to more regulations, tighter enforcement, further limitations on freedom and further deterioration of the quality of medicine.

MEDICAL SCHOOL ENROLLMENT RECORDS

All records for enrollment in approved medical schools in the United States were broken in the past year.

This is brought out in the annual report of the American Medical Association's Council on Medical Education and Hospitals, published in the September 9 journal of the association.

The total enrollment in the seventy-two medical and seven basic science schools for the academic year 1949-1950 was 25,103. This represents an increase of 1,433 students, or 6 per cent, over the preceding year. The latest total is double the enrollment in 1910 (12,530), about 18 per cent higher than 10 years ago, and even larger than during the years of World War II, when extra classes were enrolled in all medical schools on an accelerated program.

From July 1, 1949, to June 30, 1950, 5,553 physicians were graduated from approved medical schools in the U. S., an increase of 459 over the preceding year. This is the largest number graduating from approved medical schools in the nation in one year except for the years 1946 and 1947, when several schools at the conclusion of their wartime program graduated more than one class during a twelve months' period.

On the basis of enrolments in the senior class for 1950-1951, the medical schools of the U. S. have estimated that they will have slightly more than 6,000 graduates during the coming year.

The freshman class for the first time exceeded 7,000 students during 1949-1950. The actual number, 7,042, represented an increase of 354, or 5.3 per cent, over the preceding year and an increase of 1,026, or 17 per cent, over the average size of the freshman class in the 10 years preceding World War II.

The freshman class that will enter medical school this fall will be even larger. On the basis of the record of the past year, the new schools that are being organized and the expansion of existing schools that is under way, it now seems likely that within the next few years the freshman class will number close to 7,500 students.

Women totaled 1,806, or 7.2 per cent, of the medical students in this country, compared to 2,109, or 8.9 per cent, in the preceding year. The percentage of veterans enrolled in the medical schools and schools of basic medical sciences in the U. S. during 1949-1950 was 65.9 per cent, which is almost identical with the figure 65.8 per cent for the preceding year.

The budgets of the medical schools and basic science schools for the 1950-1951 fiscal year total about $67,500,000, representing an increase of about 42 per cent in the last four years. It also said that figures of the cost of new construction, completed, started or authorized during the last year, were available for only one half of the projects reported and the total cost of these was more than $100,000,000.

Cancer Comment

WHY CANCER PATIENTS DELAY SEEKING DIAGNOSIS AND TREATMENT

It has long been recognized that the great majority of cancer patients are incurable when first seen by a physician. Why do these conditions exist?

Many factors bear upon this problem. Different reasons apply to different patients. King and Leach (*Cancer,* July 1950) discuss this question in considerable detail and explain some but not all the reasons. Extent of the patient's knowledge of the nature of cancer, particularly the significance of early signs and symptoms is one major factor. The less informed delay the longest in the majority of cases.

Emotional attitudes toward the disease, fear of consequences of treatment, especially of early postoperative death, and an inability to face the knowledge of the presence of cancer, are all major factors in patient delay. Some would rather be spared the knowledge that they had cancer, even in early hopeful stages, than to know of its presence. They seem to be happier by assuming a detached attitude toward the problem, even in the absence of any religious beliefs they may have regarding disease in general.

Another group of cancer patients, composed of wives and mothers, often hesitate to seek medical help because of their home responsibilities and their fear of the neglect of their families in cases of prolonged disability or death.

Many patients hesitate to seek medical examination for seemingly slight and nondisabling symptoms, fearing the implied or expressed ridicule of the physician over such "trifling matters."

Age is also a factor; the older the patient when symptoms first appear the less likely is he to seek medical advice. Many such patients have had little contact with physicians throughout their lives and hesitate to consult them in their old age. They have developed a more or less fatalistic attitude toward their health problems.

Investigations have shown that because of frequent change in residence or other reason, a high percentage of cancer patients who delay in seeking medical advice do not have a family physician, hence are at a loss as to who should be consulted for their present condition.

One important fact that stands out in the discussion of the causes of delay in seeking medical help in cancer is that very few patients delay because of financial reasons. The statement is often made that many cancer patients cannot afford the necessary diagnosis and treatment because of the excessive costs involved. King and Leach found in their study referred to previously that "it appeared that delay in medical care was independent of income and all other economic factors, excluding hospitalization insurance." This confirms the findings in the Michigan Cancer Survey where but 2 per cent of the delay in 734 cases could be traced to financial reasons.

Another reason often assigned for delay is that of temporary subsidence of symptoms. As pain or other discomfort is the most common symptom compelling medical consultation, many patients refuse to seek medical advice in its absence.

The reasons for delay discussed above, and other reasons that apply to individuals, indicate the extreme importance of a widely expanded and intensified lay education program. Knowledge about cancer has far outrun its application to the saving of life. Too many potential cancer patients—which includes the entire population—have not had the knowledge of how to control cancer effectively impressed upon them. A recent national survey revealed that almost one-half of those questioned could not name one symptom of cancer, that one in seven still thinks cancer is contagious, that many still believe it is incurable and disgraceful.

The most promising educational group today is in the high school and college ages. These young people rapidly approaching maturity can and should be taught the facts about cancer in their regular health studies. Experience has proved them capable of understanding and profiting from such instruction both in safeguarding their own health and that of their immediate families. Unlike their elders, their ideas about cancer have not yet become fixed in wrong channels. After forty-five—and even after twenty-five—education is not as effective as during the earlier years.

(Continued on Page 1315)

Annual Session Echoes

ATTENDANCE IN 1950

A total registration of 3,044 was marked up at the 85th Annual Session of the Michigan State Medical Society in Detroit, September 20-21-22, 1950. The breakdown of this high registration was as follows:

Doctors of Medicine	2,205
Residents, interns, guests	374
Exhibitors	465
Total attendance	3,044

TOP COVERAGE BY PRESS, RADIO AND TELEVISION

C. E. Umphrey, M.D., Detroit, *President*

One of the busiest places at the MSMS Annual Session was the Press Room. The enlightened co-operation of the ubiquitous hosts provided conferences between guest essayists and science writers which were productive of good publicity the like of which few medical meetings either obtain or merit. Thanks to the effort of Jack Pickering, *Detroit Times,* Robert Goldman, *Detroit Free Press* and Allen Shoenfield, *Detroit News,* the front pages of these three metropolitan dailies carried highly accurate accounts of the manuscripts and proceedings of the session.

O. O. Beck, M.D., Birmingham, *President-Elect*

The printed word was complemented by photographers' flash bulbs, television cameras and radio microphones which carried to the people the basic message that the doctors were alert to the problems of today's health and were doing something about them! Wire services were also generous in their time allocation to the material presented.

"Extra-conference" presentations were made as follows:

Service Club Talks

Place—Station	*Program—Arrangements*	*Date-Time*
Grosse Pointe Rotary	L. Fernald Foster, M.D. War Memorial 32 Lake Shore Drive	Sept. 18 Monday—noon
Main Line Lions	J. S. DeTar, M.D. Statler Hotel	Sept. 19 Tuesday—noon
Public Health Nurses of Wayne County	Hugh W. Brenneman St. Paul Evangelical Church	Sept. 19 Tuesday—noon
Main Line Kiwanis	L. Fernald Foster, M.D. Statler Hotel	Sept. 19 Tuesday—12:15 p.m.
Medical Assistants Meeting	Hugh W. Brenneman Detroit-Leland Hotel	Sept. 20 Wednesday —11:00 a.m.
East Side Lions	W. B. Cooksey, M.D. Whittier Hotel	Sept. 20 Wednesday —12:15 p.m.
Woman's Auxiliary	Russell F. Staudacher Statler Hotel	Sept. 21 Thursday—noon
Medical Assistants Meeting	L. Fernald Foster, M.D. E. A. Osius, M.D. Detroit-Leland Hotel	Sept. 21 Thursday —noon

TV Show

Bob Murphys' Matinee	C. E. Umphrey, M.D. H. F. Becker, M.D. (Live)	Sept. 18 Monday

Radio Programs

WJBK-TV	A. A. Humphrey, M.D.	4:30 p.m.
Radio Station WJR	E. L. Henderson, M.D. House of Delegates (transcribed)	Sept. 19 Tuesday—10:45 p.m.
Radio Station WXYZ	H. F. Becker, M.D. A. A. Humphrey, M.D. L. Fernald Foster, M.D. (transcribed)	Sept. 21 Thursday—1:15 p.m.
Radio Station WWJ	A. H. Whittaker, M.D. Kenneth Johnson, M.D. Ray Waggoner, M.D. (Live)	Sept. 21 Thursday—7:30 p.m.
Radio Station CKLW	James Fyvie, M.D. E. F. Sladek, M.D. L. Fernald Foster, M.D. Hugh W. Brenneman (moderator) (transcribed)	Sept. 22 Friday—11:00 p.m.

(Continued on Page 1274)

TOP COVERAGE

(Continued from Page 1272)

Radio Programs

Radio Station WJR	L. Fernald Foster, M.D. C. E. Umphrey, M.D. J. S. DeTar, M.D. "In Our Opinion" Cushing (transcribed)	Sept. 24 Sunday— 12:30 p.m.

FIFTY-YEAR CLUB TOTALS 137

Although only four years old, the "Fifty-Year Club" gained seven members to swell its total enrollment to 137. Founded for the purpose of paying tribute to those physicians who have practiced medicine for a half century or longer, the induction into office has become a standard feature of the Officers' Night ceremonies at the MSMS Annual Session.

Inducted this year were: George R. Pray, M.D., Jackson; Edward O. Sage, M.D., Detroit; Edward B. Ramsey, M.D., Detroit; Lewis L. Stewart, M.D., Jackson; H. H. Learmont, M.D., Croswell; Wm. J. Stapleton, Jr., M.D., Detroit; and Charles Norton, M.D., Detroit.

DR. DeTAR HONORED

J. S. DeTar, M.D.

Additional honors came to J. S. DeTar, M.D., Milan, Councilor of the Fourteenth District, when he was presented with a Past Speaker's Key emblematic of his three terms as Speaker of the House of Delegates of the Michigan State Medical Society. The award was made during the Officers Night ceremonies at the 85th MSMS annual session, on Wednesday, September 20, 1950, and was presented by President W. E. Barstow, M.D., St. Louis, Michigan.

WHAT THEY THOUGHT OF THE 1950 MSMS ANNUAL SESSION

E. L. Henderson, M.D., Louisville, Kentucky, (President, American Medical Association): "I have just returned to the office from my trip to Detroit and Omaha and I want to take this opportunity to thank you for the many courtesies which I received while in Michigan. I have never been more royally entertained and taken care of better than during my stay there and I cannot tell you how much I appreciate it.

"I also wish to thank you and the Michigan State Medical Society for the wonderful scroll which was presented me. I appreciate it very much indeed and it shall occupy a prominent place in my office.

"Again thanking you for your many courtesies and with regards and good wishes."

* * *

W. A. Altemeier, M.D., Cincinnati, Ohio, (Guest Essayist): "I wish to express my sincere appreciation for the kindness and hospitality shown me by my host, Doctor George Moriarty, and by the Michigan State Medical Society during my recent trip to Detroit."

* * *

Edward I. Bortz, M.D., Philadelphia, Pa., (Guest Essayist): "My sincere thanks to you. I have never been more graciously entertained in my life. The few hours I spent in Detroit were thoroughly enjoyable. It pleased me to note the cordial and interesting reception to my remarks. I was also gratified by the unusual interest of the audience during the question and answer period."

* * *

H. W. Brown, M.D., New York City, N. Y., (Guest Essayist): "I want to congratulate the Michigan State Medical Society and especially you, for the efficient way in which the convention was handled. Every need and desire seemed to be anticipated and arranged for in advance. Mrs. Brown and I had a most delightful time during our stay, all made possible by the kind efforts of Dr. Gemeroy.

"Thanking you for the invitation to take part on such an outstanding scientific program."

* * *

J. O. Christianson, St. Paul, Minn., (Biddle Orator): "Thanks again for your many courtesies and the beautiful scroll."

* * *

S. A. Cosgrove, M.D., Jersey City, N. J., (Guest Essayist): "Please accept the deepest appreciation of Mrs. Cosgrove and myself for the great courtesy shown us during the recent State Society meeting by everyone of your members and especially by Doctor Darling of Detroit."

* * *

Charles A. Doan, M.D., Columbus, Ohio, (Guest Essayist): "Just a further written expression of my personal statement to you while in Detroit last week, in genuine appreciation of the fine courtesies extended by the Michigan State Medical Society to its guest speakers. I have never attended any meeting where the arrangements had been so perfectly anticipated in detail. Doctor McBroom and Doctor Pollard were delightful and efficient social and seminar hosts, respectively, and I want to tell you, officially, how completely this discharge of their respective duties was handled.

"I particularly was impressed with the individualization of your planning in so large a scientific program, reflected in the change which you so promptly and graciously made in altering the hour of my seminar discussion from 5:00 p.m. to 4:00 p.m. because of my Washington, D.C., commitments the following day. I only hope that I may have been able to bring to the membership the information and enthusiasm which they deserve.

"Once again, congratulations on an unusually complete and effective organization without the loss of the personal touch all along the line."

* * *

Frederic A. Gibbs, M.D., Chicago, Illinois, (Guest Essayist): "I greatly enjoyed the opportunity to attend the meeting of the Michigan State Medical Society as a guest speaker, and was delighted with all the arrangements which were made in my behalf. It was a pleasure to meet so many old friends and to make new acquaintances among those who are particularly interested in epilepsy."

* * *

L. F. Hill, M.D., Des Moines, Iowa, (Guest Essayist): "My participation in your 85th Session was a pleasant experience indeed, and Dr. Ed. Martmer, my host, took excellent care of me."

(Continued on Page 1276)

WHAT THEY THOUGHT OF THE 1950 MSMS ANNUAL SESSION

(Continued from Page 1274)

John R. McDonald, M.D., Rochester, Minn., (Guest Essayist): "I wish to thank you for the invitation to talk as well as the wonderful hospitality which was extended to me during my stay in Detroit. I am writing Dr. Kaump to thank him for the time he spent with me in making my stay so enjoyable."

* * *

W. F. Mengert, M.D., Dallas, Texas, (Guest Essayist): "May I thank the Michigan State Medical Society through you for their courtesy in looking after me in Detroit. I greatly appreciated coming to the meeting and am only sorry that my stay of necessity was so brief."

* * *

G. C. Prather, M.D., Brookline, Massachusetts, (Guest Essayist): "I must repeat that I believe you have the annual meeting beautifully organized, so that certainly as far as your guest speakers are concerned there could be no improvement in the management thereof."

* * *

J. T. Priestley, M.D., Rochester, Minn., (Guest Essayist): "I would like to thank you for the opportunity of attending the meeting of the Michigan State Medical Society and for the unexcelled hospitality which you extended to me at that time. You and your associates certainly are past masters at putting on a medical meeting of quality, and you treated your guests in a manner which makes them wish to return soon."

* * *

Anthony Rottino, M.D., New York, New York, (Guest Essayist): "I wish to thank the Michigan State Medical Society for your invitation to me for the fine courtesy shown to me by members of the Society. I enjoyed talking to the quiz group which was quite stimulating. I was delighted with my ubiquitous host, Doctor Kasper."

* * *

Fredrick F. Yonkman, M.D., Summit, New Jersey, (Guest Essayist): "We appreciated the kind letter from President Barstow and Secretary Foster which we received upon arriving at the Book-Cadillac, Thursday night. We very much regret that we could not attend all of the festivities as of Wednesday morning on, but our schedule did not permit our taking advantage of the opportunity. Our stay in Detroit was most enjoyable and I assure you it was a pleasure, as well as a privilege, to be able to contribute to your program."

* * *

Ira G. Downer, M.D., Detroit, (Ubiquitous Host): "Guest Essayist, Raymond W. McNealy, M.D., just called me long distance to tell me again what a nice time he had at the MSMS Annual Session. All in all, it was mutually a very pleasant experience for all of us."

* * *

A. M. Campbell, M.D., Grand Rapids, (MSMS Member): "Again I am happy to have lived another year and to congratulate you on the splendid meeting of the Michigan State Medical Society. I think it was one of the best programs that you folks have ever put on. In fact I think it is the equal of any national program."

* * *

W. S. Nolting, M.D., Detroit, (MSMS Member): "A word of congratulation on the efficient way the meeting went along. The essayists certainly felt that the officers in charge did a splendid job arranging so many details.

"Again, my compliments for a good meeting well done."

* * *

Mac F. Cahal, Kansas City, Mo., (Executive Secretary, American Academy of General Practice): "What a remarkable meeting you had! After being there and experiencing the enthusiasm, one does not wonder that you enjoy such an outstanding reputation with the technical exhibitors."

L. H. Ashe, (E. R. Squibb & Sons, New York City), President, Medical Exhibitors Association: "On behalf of the Medical Exhibitors Association and all of its members, and, more particularly, myself and wife and those past and present officers who were privileged to attend the Exhibitors Gridiron dinner, I want to thank the Michigan State Medical Society most cordially for their initiative in extending this tribute to us, and for the many courtesies which were shown us during our visit in Detroit."

* * *

Frank M. Rhatigan, (Davis & Geck, Inc., Brooklyn, N. Y.), Past President MEA: "I am very happy that the MSMS Annual Session and especially the Gridiron Dinner turned out to be such a success. So far as the MEA is concerned, I am quite sure they will go on record with some form of recognition to the Michigan State Medical Society for the honor that was paid to us on September 21, 1950."

* * *

H. J. Cowell, (Lea & Febiger, Philadelphia, Pa.), Past President of MEA: "I would not have missed your 20th anniversary celebration of the founding of the Medical Exhibitors Association for anything. You, your staff and the Michigan State Medical Society, are due for congratulations all the way around."

* * *

S. A. Montgomery, (Gerber Products Company, Fremont, Michigan): "The Michigan State Medical Association always arranges exhibits efficiently. Intermissions between sessions are arranged during the mornings and afternoons. This encourages physicians to visit exhibitors. Michigan State Medical Society always produces a good show both from the physicians' and the exhibitors' viewpoint."

* * *

James T. Beers, (Coca-Cola Company, Atlanta, Georgia): "I can't begin to tell you what a pleasure it was for me to have visited at the Michigan State Medical Convention. We always look forward to our participation at this show as we consider it tops. I appreciate your hospitality more than I can say."

* * *

George A. Triplett, Detroit, (Medical Protective Company, Fort Wayne, Indiana): "Just a note to congratulate you on your usual superb job of running a medical meeting and to thank you. It was most delightful and I appreciated being included."

* * *

Wm. F. Funkhouser, (C. B. Kendall Company, Indianapolis, Indiana): "We wish to thank the many old and new physician friends who registered at our Exhibit Booth during the 1950 Convention. Because of your kindness and the capable direction, we consider the Michigan State Medical Convention tops on our budget list for convention exhibits."

* * *

G. Theodore Fredstrom, (Wm. S. Merrell Company, Cincinnati, Ohio): "We wish to say it was a pleasure to attend your meeting this year, and look forward to receiving the prospectus for your 1951 assembly."

CORRECTION

ACTH and Colchicine in the Clinical Treatment of Acute Gouty Arthritis (Wolfson et al: J.M.S.M.S., 49: 1058, September, 1950):

The dosage should be as follows: .00065 gm. of colchicine (1/100 gr.) is given four times daily, and reduced to .00065 gm. three times daily if not well tolerated. Further reduction is to .00065 gm. twice daily.

The article contains a second error. In Figure 1, the lower righthand subdivision should show 44 per cent of previously untreated patients as responding to 50 mg. or less of ACTH, rather than 54 per cent as indicated in the published figure.

MICHIGAN LAWYERS OPPOSED TO SOCIALISM

Michigan's legal profession through its state organization, the State Bar of Michigan, has again reaffirmed its opposition to any form of socialized medicine. The action of the lawyers was taken Thursday, September 28, when the group passed a strongly worded resolution at its 1950 Annual meeting in Grand Rapids.

The resolution which puts the State Bar among the strongest supporters of the free enterprise system was introduced in the State Bar by LeMoyne Snyder, M.D., East Lansing, prominent attorney and member of the Michigan State Medical Society.

The complete text of the Resolution follows:

"WHEREAS, such legislation as S. 1679 will to all intent and purposes centrally control and socialize medicine and politically control medical practices, and constitutes a direct attack on the rights and liberties of the citizens of this country; and

"WHEREAS, Compulsory Health Insurance wherever tried has caused a decline in national health and a deterioration of medical standards and facilities; and

"WHEREAS, Socialized medicine such as proposed by Senate Bill 1679 has never proven to be of advantage either to the patient, the medical profession or the community in which it is adopted; and

"WHEREAS, whenever the Government has assumed control of medical services, the result has been tremendous multiplication of costs over original estimates, extreme tax burdens and National deficits, and gradual extension of socialization into other activities of National life; and,

"WHEREAS, the American Bar Association in 1944, disapproved S. 1161 and reiterated its opposition to socialized medicine in 1949 by opposing S. 1679; now, therefore be it

"RESOLVED, that the State Bar of Michigan does hereby go on record as opposing S. 1679, and similar legislation, which will subject the practice of medicine to federal control and regulation beyond that presently imposed under the American system of free enterprise; and be it further

"RESOLVED, that a copy of this resolution be forwarded to each Senator and Representative from the State of Michigan, and that said Senators and Representatives be and are hereby respectfully requested to use every effort at their command to prevent the enactment of such legislation."

A competitive examination for appointment of Medical Officers in the Regular Corps of the United States Public Health Service will be held on February 12, 13, and 14, 1951. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received no later than January 15, 1951.

The JOURNAL

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American Medicine Looks Ahead

By Elmer L. Henderson, M.D.

President, American Medical Association

I APPRECIATE this opportunity to speak here in Michigan, for no state in the Union provides a better example of the vitality and the benefits of the American way of life.

Your great automobile industry, as just one case in point, typifies the growth and initiative of all American industry, the rising standards of American living, and the constant improvement in relations between American labor and management.

Likewise, Michigan's physicians, dentists and nurses, fine hospitals and medical schools, and state public health program exemplify the high standards and modern methods which have made the United States the healthiest major nation in the world.

And the Michigan State Medical Society, in particular, represents the progressive thinking and positive action which constitute the *true* policy of the entire American medical profession—a policy sincerely devoted to the maintenance of high standards, the protection of the public health, and the provision of adequate medical care for all the people.

I emphasize the word *true* because our policies and motives have been so crudely and maliciously distorted by the advocates of socialized medicine in America. One of the favorite distortions, for instance, is the charge that the medical profession is a so-called "close corporation," which "is trying to hold down the number of new doctors." This is utterly false—and the refutation of the charge lies no farther away than the facts of the matter right here in Michigan.

In 1948 the House of Delegates of the Michigan State Medical Society passed a resolution urging an *increase* in the number of graduates from the medical schools in this state. The state medical society followed up this action by asking the Michigan Legislature to grant money for additional medical school facilities at both the University of Michigan and Wayne University.

Since then, as a result of further efforts in which Michigan doctors played a major role, the state legislature has authorized the construction of a medical center building at the University of Michigan Medical School, and the development of plans for a Medical Science Building at Wayne University College of Medicine.

The Michigan State Medical Society was the prime mover in the three Michigan Rural Health Conferences called in 1947, 48 and 49. Those conferences emphasized ways and means of increasing facilities for the training of doctors, establishing more facilities for the practice of medicine in rural areas, and setting up a loan fund for medical students who will agree to practice in rural areas.

The Michigan State Medical Society has given financial support to the Michigan Health Council from the time of its formation. The Society has worked actively with the Council to help achieve one of its major objectives—widespread public support for increased medical education facilities. Here in Detroit, on October 1, the Michigan State Medical Society and the American Medical Association's Council on Medical Service will be joint sponsors of a National Conference on "M.D. Participation in Health Councils."

The Michigan State Medical Society has urged continuation of the present policy on admissions to medical schools—a policy based solely on merit and aptitude, regardless of race, creed or ancestry—in

Delivered before the House of Delegates of the Michigan State Medical Society, September 19, 1950, Detroit, Michigan.

order to obtain the best qualified and maximum number of doctors.

Finally, at this convention this week, the Michigan State Medical Society will be discussing new plans for an increased effort on behalf of Michigan's two Grade A medical schools—plans calling for additional funds from the state legislature and the public-spirited citizens of Michigan, so that both facilities and faculties will be adequate to meet the present and future need for doctors.

Those are the facts in Michigan. And the facts in Michigan are typical of actions and programs throughout the nation. State and county medical societies in all parts of the country—in co-operation with public and private agencies and the general public—are working actively to increase the funds available for medical education . . . to provide more scholarships and loans for medical students . . . to place doctors in communities which need them . . . to set up clinics or other medical facilities where they are needed . . . to guarantee adequate medical care to everyone, regardless of ability to pay, and regardless of the time of night or day . . . to aid the rapid growth and improvement of all sound voluntary health insurance plans . . . and to give the public more and better information on problems of health and medical care.

These and similar programs have more than just the approval of the American Medical Association. They represent the national policy of the medical profession, and the American Medical Association has been urging the full development of such progress in every state, county and locality.

This is the *voluntary* way, the *American* way, the *successful* way to solve our problems—medical or otherwise. This is the way which has made our nation great and strong.

American medicine is determined to preserve that way of life. We firmly believe that national compulsory health insurance—which would place both patients and doctors under centralized, federal control—is a definite threat to the American way of life. For the experience of other nations demonstrates that the socialization of medicine would be only a first step toward the ultimate regimentation of all American life.

Now, at this critical point in American history, the medical profession faces a task that will require double effort, double vigilance and double victory.

Our first responsibility, as doctors, is to serve the health and medical needs of all Americans—in civilian life or in the armed forces, on the home front or on the battle front—wherever and however we are most capable of serving. It goes without saying that we medical men never will allow events of the past to interfere with patriotic duties of the present.

Our second responsibility, as citizens in the arena of public affairs, is to dispel completely any notion that our crusade against socialized medicine is merely a temporary outburst—in the nature of an epidemic or a flash flood. In this phase of our double task we must maintain and strengthen our professional unity—we must continue our direct, successful contact with the American people—we must be alert to the maneuvers and machinations of the home front socializers—and, above all, we must not be decoyed out of our position on the basic issue of freedom for medicine, and freedom for all America. Quite to the contrary, we must make that position strong and crystal clear.

For now—with our own nation once again emerging as the chief defender of freedom, in a world of tension and danger—medicine's cause has greater validity and greater significance than ever before. If Americans are to work and fight in the name of freedom elsewhere in the world, logic demands that we preserve freedom in our own country. If there is to be practical meaning and moral purpose in the sacrifices of our fighting men abroad, then it becomes a national duty to guard basic American principles here at home. Any other course would be a tragic betrayal of both men *and* principles.

Fortunately, at this time of emergency, the American people are rallying to that point of view. As patriots, they naturally accept the necessity for temporary controls, limitations and directives during a period of national crisis. But they also recognize that a threat to basic American freedom already existed in this country, prior to the present war emergency. As a result, there has been an ever-increasing sense of vigilance—a growing awareness of danger.

We can be proud of the fact that medicine's national education campaign has played a major role in alerting the American people to the internal threat. In that campaign, since January, 1949, the nation's doctors have gone directly to the American public with the facts about compulsory health insurance—how it would affect the quality of medical care, the national health, the taxpayer's

pocketbook and, ultimately, the foundational structure of all American life. At the same time the campaign has stressed the positive story of American medical progress, the growth of voluntary health insurance, and the over-all vitality of a national philosophy based on individual initiative and freedom of action.

As a result of that effort—carried out openly in the area of public opinion—more than 10,000 national, state and local organizations, with many millions of members, have taken positive action against compulsory health insurance, or any other form of socialized medicine. Moreover, they have recognized that socialized medicine would be only the precedent—the first step—the infiltration maneuver—leading to the eventual death of the free enterprise system.

Medicine's campaign, winning a massive cross-section of public support, has spearheaded and stimulated an ever-broadening opposition to all forms of state Socialism in America. It has given courage and inspiration to thousands of individuals, organizations and groups who also like the American way of doing things. It has helped to rekindle a pride in the American past, a faith in the American future.

We can be thankful that this situation exists, especially now that the tragic possibility of a third world war looms on the horizon. But at the same time we cannot be lulled by past success. We must face the fact that a clear and present danger still exists here on the home front. That danger is the trend toward state Socialism—a trend which has been exposed but not eliminated, slowed but not stopped.

It is therefore imperative, in my opinion, that both doctors and laymen keep in mind the dismal lessons of recent history, and the unpleasant facts of the present. In other words, we must watch both the forest *and* the trees.

The lessons of history are that both World War I and World War II set the stage for drastic internal changes in many nations. In a number of cases, those changes either killed or restricted freedom. The First World War, for example, was the catalyst for the development of Russian Communism, Italian Fascism and German Nazism. The Second World War, more recently, brought the emergence of Socialism in freedom-loving Britain, the fall of the Iron Curtain on the European Continent and the surge of Communism in China and other Asiatic countries.

The unpleasant facts of the present are that today—behind the scenes right here in America—there are people who would like to change the basic structure of this nation. Lurking in the background of American life there are—as I said in my San Francisco inaugural address—"little men whose lust for power is far out of proportion to their intellectual capacity, their spiritual understanding, their economic realism of their political honesty."

These men of little faith in the American people—I pointed out in my presidential address—seek socialized medicine only as a first goal. Their real objective is to gain control over all fields of human endeavor and make this a Socialist state.

In that connection I should like to repeat one more statement I made in San Francisco. It is this:

"There is only one essential difference between Socialism and Communism. Under state Socialism human liberty and human dignity die a little more slowly, but they die just as surely!"

Keeping in mind all of these factors—the lessons of the past and the realities of the present—there can be only one logical course of action, for us doctors and for all Americans who value freedom. That is a continued, vigorous, expanding mobilization of faith—a spiritual rallying of all those who believe in the American way of life and are determined to preserve it—a constant vigilance that will make this nation invulnerable to all enemies of freedom, wherever they are.

To help bring about such a sweeping reaffirmation of faith—a rousing people's mandate for Americanism—will be the primary objective of medicine's nationwide advertising program in October. Utilizing every bona fide daily and weekly newspaper in the country, some thirty national magazines and more than 1,500 radio stations, that program will carry our message of freedom to every American. Also participating, with paid space of their own, will be thousands of individuals, companies and groups whose advertising will echo the same basic theme. I urge all of you to do everything you can to help this major effort become a history-making success.

Another vitally important phase of the action which I consider necessary, is the participation of individual doctors in the elections this fall. Many doctors all over the country already are exercising their political rights as individual citizens. Regardless of their previous party affiliations, they

are working actively for all candidates—whether Democrats, Republicans or Independents—who sincerely believe in fundamental American liberties, and who are determined to preserve those liberties. Again, for the sake of freedom in medicine, and freedom in the entire American future, I urge all of you to do likewise.

For we find, as American medicine looks ahead in this period of world danger, that we no longer can confine ourselves to a long-range professional progress. We find that before American medicine can move ahead to the great accomplishments which will be possible in future decades, it first will be necessary to concentrate on an urgent, immediate task. That task is to safeguard freedom now, in the months and years immediately ahead, so that there will be a future—for doctors and all Americans.

I am confident that American doctors—in their capacities as both medical men and citizens—will do their part. And I am confident that the American people, with God's help, will overcome the present threat to freedom—both at home and abroad.

My remarks are for doctors generally. I might make some remarks here in the presence of doctors that I would not like to make over the radio. For that reason I reserved some remarks until after I talked on the radio.

The other day a memorandum came across my desk from one of the leading dentists of the country. He made the remark in a rather critical way that in my talks before groups throughout the country I failed to include dentists. I do not think we have any dentists here this evening, but when I talk about doctors I include physicians and dentists. The dentists are somewhat sensitive. Sometimes they are critical if you refer to "physicians and dentists." When I talk of the medical profession I naturally include the dentists. When I talk of the fight against socialized medicine and socialization in general I speak of all of our allied professions, because we need all of our allied professions, and they are grouped with us and should fight right along by our side. The druggists throughout our country as well as the dentists are doing a splendid job; they are co-operating with us 100 per cent in our fight against compulsory health insurance. I say they are fighting and co-operating 100 per cent. I mean insofar as the doctors are concerned. You must remember that we have a certain group of doctors in this country who are not co-operating 100 per cent.

I have here a little pamphlet that I would call to your attention too. Probably some of you have seen it, and also this other pamphlet. They look just the same from where you are sitting. They are just the same, except for the frontispiece. For instance, this pamphlet was put out by the Committee for the Nation's Health, known as the National Health Insurance Handbook. "A Practical Guide for Leaders," Committee for the Nation's Health, 1416 F Street, N. W., Washington, D. C.

Here is the same booklet, with the title, "Administration's Health Program," Training Kit for Leaders, Democratic National Committee, Ring Building, Washington, D. C. That booklet has been sent out all over the country to Democrat workers, throughout the states and counties and precincts of this country.

Now, gentlemen, I am not a partisan politician. The truth is that I have been registered a Democrat as long as I have been able to vote but not a Socialist Democrat. We certainly have plenty of them in this country. If we are to fight socialism we have got to fight the organizations that are getting out and fighting us. Any other course would be a tragic betrayal, not of our profession but of the American people. I urge all of you to get out and fight for the men who are willing to stand up for the American way of life, for the American principle, not only in medicine but in all stems of American life.

American medicine is stronger today than ever in the history of American medicine. We have more unity in the medical profession today than ever in the history of our profession. That has required a lot of work; it has necessitated overcoming many problems. However, you do not hear today the bickering in the medical profession that you heard a few years ago.

The doctors of this country can control any election if they get out and work at it. I think the results of the election in Florida and also in North Carolina thoroughly demonstrate that. In Florida a great many people thought it would be impossible for them to defeat Senator Pepper, but he was defeated. The doctors and their wives and their office help and the allied professions, the dentists and their wives and the pharmacists, all of them went in together, and don't forget the Women's Auxiliary. They did a wonderful job down there,

(Continued on Page 1287)

President's Address

By W. E. Barstow, M.D.

St. Louis, Michigan

IT WOULD BE difficult to hold the presidency of the Michigan State Medical Society without acquiring a sense of deep humility.

Without the fellowship, generous assistance, and genuine co-operation of all participating in our work during the past year, little could have been accomplished.

Having had such help, I can remember our work with some satisfaction. I am extremely grateful to those who have made that work possible.

The problems faced by the society have been many and serious. It would be pleasant to talk of a finished job, but most of our program just hasn't presented matters capable of immediate or final solution.

A most important example of the long-range nature of these problems has been our defense against political medicine proposals and anti-trust investigations by our national government.

These attacks have obviously been attempts by unprincipaled men to control and administer medical services as a vote-getting tool, and are therefore extremely dangerous.

They are aided by dreamers who feel that just a little more governmental planning and regulation would solve everyone's troubles.

Someone has suggested that if the "Fair Deal" administration is so insistent on establishing a bureau to improve medical services, it might best create one dedicated to seeing that the medical profession is left alone by the overpaternal government and carpet-bagger politicians.

Most doctors are inclined to agree with this hypothesis. We believe that Americans appreciate their traditional democracy, and fear the obvious freedom-strangling effects of Socialism in the welfare state pattern.

We further believe there is nothing wrong with medical services that more doctors and voluntary insurance plans won't cure.

The CAP program of our society was designed to publicize the fact that recent compulsory health insurance proposals are just disguised Socialism, and to persuade everyone to vote accordingly, but especially to vote. It has met with a good degree of success. But the work of the past is only a foretaste of the work necessary for the future.

A second major phase of our work has been general public relations. The medical profession merely wants the public to hear and evaluate the truth, but years of bitter experience were needed to teach us that we must enter actively into public relations work in order to be certain that the truth is available to all.

Much of our recent public relations work has been devoted, of course, to the fight against socialism. Nevertheless, mediation of problems arising from the physician-patient relationship, and encouragement of constructive state legislation, have received competent attention.

The program of continuing and extending postgraduate educational facilities has been rewarding and worthwhile. Co-operative work in diagnosis and control of heart disease, cancer and rheumatic fever has been a nationally outstanding example for the handling of problem areas in our own professional field.

But much still remains unaccomplished. While we have given the society a year of hard work, we leave also a legacy of still more work ahead.

Like the practice of medicine itself, officership in the Michigan State Medical Society merely provides an opportunity for public service.

Our reward lies in the knowledge that next year's program will be in such able and willing hands.

Presented at the General Assembly, Wednesday Evening, September 20, 1950, at the annual session of the Michigan State Medical Society, Detroit.

MSMS

Any American fighting men wounded in Korea are being evacuated by air, if armed forces plans revealed to the American Medical Association are being followed.

Hospital trains and hospital ships are out, in military medical planning. As long ago as last August (1949), air evacuation was adopted as "the sole method of patient movement for the armed forces, replacing hospital ships and hospital trains," Lieut. Col. B. A. Strickland, director of the military medicine division of the Air Force School of Aviation Medicine, announced.

Over 1,423,263 patients were evacuated by air between 1942 and 1949, he reported. Since 1945 only one death has occurred in air evacuation.—*Science News Letter*, July 8, 1950.

Ten Per Cent N-ethyl-o-crotono-toluide Ointment in Treatment of Scabies Infestations

By Eugene A. Hand, M.D.

Saginaw, Michigan

CHEMISTS[1] of the Dow Company found, after studying many organic toxicants by the Peet Grady method of determining the knock-down and kill percentage on five-day-old houseflies, that the addition of a N-hydrocarbon-substituted crotonamide to rotenone, pyrethrin and derris root greatly increased the ability to knock down and kill. They studied a large number of these crotonamides, in combination with rotenone, pyrethrin and derris roots extracts and many were found to be non-irritating and free of offensive odor.

Domenjoz,[4] from a study of the acaricidal properties of over 1,100 new synthetized products *in vitro* on Psoroptes Cuniculi, the scabies mite in rabbits, found a number of excellent arcaricidal agents. Of these N-ethyl-o-crotono-toluide, ethylamide of the p-chlorobenzene-sulfonic acid, and 1) p-chlorophenoxy-2-oxy-3-chloro-propane after therapeutic experiments and tolerance tests in infected rabbits, guinea pigs, rats, mice were deemed safe for human experiments.

Burekhardt and Rymarowicz[2] in a clinical trial on humans with these three preparations dropped the last two due to secondary symptoms such as dizziness and headaches. With 10 per cent N-ethyl-o-crotono-toluide in a ointment base they observed no secondary symptoms. They treated a large number of scabietics with this ointment with excellent clinical results. In their practice this odorless clain ointment promptly cured scabies, and was nonirritating even to the eczematous and pyodermatous skin.

These excellent results have been confirmed in this country. Tronstein[6] treated six persons with severe and fourteen with mild scabies by a single application of Eurax with 90 per cent cure. He treated twenty-two with severe and sixty-seven with mild involvement by two applications with only one failure. Couperus[3] treated seventy-seven cases of scabies with 10 per cent N-ethyl-o-crotono-toluide in a washable vanishing base with 100 per cent cure. He reported no local or systemic reactions. Patch tests on over 100 people were negative.

Clinical Studies

The diagnosis of scabies was made clinically in eighty-six private patients. These included all age groups. The youngest was four months and the oldest seventy-six years. Half were males and half females. All were white except for a few Mexicans. Scabies in negroes is rare in this area.

In each case an attempt was made to find the acarus elements such as the female adult, the hexapod larvae, the eggs empty or full, skeletal parts, or the scyballe using the slice, scrape, and smear method.[5]

Technique of Confirming Scabies Diagnosis Microscopically

It is best to make a careful search over the parts affected to pick out lesions that will most likely give a positive diagnosis. Ordinary rules of cleanliness and asepsis should be followed. For lesions on the fingers, on the interdigital webs, on the hands, wrists, and axillae, a sterile razor blade is used to shave off a very thin slice of the vesicle, burrow or excoriated papule. For lesions on the abdomen, genitalia, buttocks and other parts less easily reached, scraping of the lesion with sterile razor blade or Bard-Parker knife is best. The thin slice of epidermis, or the scraping, is then placed on a glass slide, covered with a cover slip, and mounted in 10 or 20 per cent potassium hydroxide solution. The slide then is examined under low power, using the high power when needed.

The clinical diagnosis was confirmed microscopically in seventy-two cases. In the other fourteen possibly due to recent treatment with sulphur and/or benzyl benzoate the acarus elements could not be found. These cases were excluded from this series.

In a number of negative cases in which the diagnosis was in doubt, a test of treatment with 10 per cent N-ethyl-o-crotono-toluide was given. The non-irritating properties of this preparation made this a safe procedure, which was never true

with the older scabietic treatments such as sulphur and benzyl benzoate. A 10 per cent ointment made of N-ethyl-o-crotono-toluide in a washable base,* was used in treating most of the patients. I have always preferred to write my own prescriptions, changing the percentage of the active ingredients and the base to fit the patient. N-ethyl-o-crotono-toluide could not be obtained commercially. The Dow Chemical Company synthetized this preparation for my use. This compound was incorporated in 5 and 10 per cent strengths in aquaphor, cold cream and petrolatum. These mixtures have remained stable over a period of one year both in the ice box and at room temperature in variable Michigan weather. My results with these ointments and the ointment furnished by the Geigy Company of New York have been identical.

The patients were instructed to bathe and then apply the ointment all over from the neck down. In babies and young children with face and scalp involvement, these areas were also treated. The ointment was applied in a similar manner on the second and third day without bathing. On the fourth day after bathing the use of fresh clean sheets, pillow cases and garments was advised. In a few cases a second short course to the affected areas only was used.

The seventy-two acarus-positive scabietics treated by this method consisted of forty mild cases and thirty-two severe cases. Eight of the seventy-two had had previous treatment and already showed dermatitis with some eczematization. Sixty-four persons were adequately followed for from two months to a year. The other eight were followed for at least two to four weeks. They were contacted by mail and urged to return at no expense for reobservation and further treatment if necessary.

Sixty-three (98.4 per cent) of the sixty-four adequately followed cleared and remained well with this treatment. There was a strong possibility of reinfection in the one failure in that the father refused to co-operate and treat himself.

There were no systemic reactions and only minimal irritation in the cases treated.

Summary and Conclusions

Seventy-two acarus-positive scabietic patients were treated with 10 per cent N-ethyl-o-crotono-toluide ointment with three applications; 98.4 per cent of those adequately followed were rapidly cured. The side effects such as dermatitis, eczematization, were minimal. There was no systemic toxicity.

I have used "Eurax" on twelve cases of pediculosis pubis with quick easy cure in each case. It was especially useful in treatment of cases with nits and pediculi on the eyelashes.

*This ointment was supplied by the Geigy Company, 89-91 Barclay Street, New York, N. Y., and is marketed under the name Eurax.

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AMERICAN MEDICINE LOOKS AHEAD

(Continued from Page 1284)

and they can do a wonderful job anywhere they are called upon to do a job, if you let them do it. If we just get out and do the job we can control the elections in this country, and that is the only way we are going to be able to defeat socialism in this country.

You cannot do that as a medical organization, as a medical society, but you can do it by organizing committees of doctors in various communities, doctors in the allied professions, such as political action committees made up of physicians and the allied professions. You can get out and really work and accomplish something. In Florida they had a letter-writing campaign. All the doctors who were interested wrote letters to all their patients. The letters were prepared and signed by the doctors in their offices and sent out over their signatures. The women went out from door to door and worked during the campaign. On election day most of the doctors closed up their offices and they and their wives used their cars to get the voters out. Those are the things that must be done if we are to control elections.

As I said before, I am not talking about any party affiliation. There are good men in all the parties, but there are socialistic men in most of the parties. It is our duty not only to preserve the American way of practicing medicine, not only to fight for the freedom of medicine, but for freedom of all Americans.

Psychiatry and the Driver

All Types of Vehicles-Land, Sea and Air

By John A. Larson, M.D.

Logansport, Indiana

A PROBLEM: With the ever-increasing traffic hazard, the importance of the handicapped driver becomes more and more real and requires detection and correction. With but rare exceptions, very few organized attacks have been made upon this acute situation by psychiatrists and psychologists. Unfortunately, although these studies are of tremendous value, there have been relatively few follow-ups, and much remains to be done. The purpose of this paper is primarily historical and for orientation—mentioning a few key contributions by psychiatrists, clinics, state laws, and how the state hospitals can assist.

In the studies published, every variety of viewpoint can be seen. One examiner in a general objective survey may show the importance of feeblemindedness, alcoholism, physical handicaps. Another examiner may emphasize, as the major factors, conflicts and stress—primarily psychogenic factors as viewed by the Freudian psychoanalyst. Another, as Selling of Detroit, formulated new psychiatric nosological criteria—Parapsychosis A and B—in his attempts to find the etiological mechanism in the driver. All are interested in the so-termed "accident-prone" driver—whether air pilot, locomotive engineer, seacraft skipper, or bus driver.

The traffic policeman focuses on speed and reckless driving. The police chemist emphasizes alcoholic impairment. The psycho-physical tests of the psychologist, employed in the examination of driving offenders, alone may be inadequate unless integrated by over-all psychiatric evaluation. Working unaided, focusing his attention on a single criterion, each worker viewing the problem in the light of his own specialty may overlook important factors and make erroneous interpretations and take wrong legal action.

Since the conclusions will depend upon the previous bias or conditioned training of the examiner, for convenience, the writer will orient his discussion from various phases of his own contact with this problem as follows:

Biological and Physiological Laboratory.—Methods of investigation, influence of heredity, race nutrition, drugs, endocrine, et cetera. Teaching and graduate research in medical schools—A.M. and Ph.D. theses concerning dactyloscopic, psychopathologic, endocrine, et cetera, factors. (A.M. thesis, "Hereditary and Fingerprints"; Ph.D. thesis, "Functional Correlation Between the Hypophysis and The Thyroid").

Pioneer police work—police psychiatry in Berkeley, California.—Four years as police investigator at Berkeley, Calif. (while doing graduate work). Introduction of a deception test and fingerprint system into police and judicial procedures. (Some of the writer's experiences at Berkeley, beginning 1921, were later summarized in *Lying and Its Detection*, in collaboration with G. Haney and L. Keeler, University of Chicago Press, 1932; various articles have appeared in legal, psychological, and psychiatric journals; a book, *Larson Single Fingerprint System,* Appleton, 1923).

In addition to the introduction of scientific methods of criminal investigation in the U. S., years before the establishment of the present Federal Bureau of Investigation in 1924, Vollmer combined these with the study of the offender. He utilized the services of a police psychiatrist, Dr. Jau Don Ball, in private practice. Dr. Ball gave courses in police psychiatry at the University of California, including demonstration clinics in the various California state hospitals. He also did psycho-physiologic studies of police officers and assisted Vollmer in the development of the Coordinated Council, later to be used throughout the country. (When Ball left Berkeley, he was followed by Dr. Chester Rowell, a neuropsychiatrist). Much of the pioneer work was done between 1915 and 1923.

Not infrequently in the past, psychiatrists discussing sex and motor-vehicle laws—whether in police courts or prison clinics—have utilized a "one premise" or "factor" approach, depending upon their major training. Few of them integrated their later, perhaps exhaustive, analytical account by the offender with the details of the act at the scene of the crime or accident.

Vollmer introduced the Atcherly Modus Oper-

Dr. Larson is superintendent of the Logansport State Hospital.

andi of England into routine U. S. procedure prior to 1921. In addition to the various criminal classifications, he devised one for traffic accidents and offenders. Also, whenever necessary, individual psychiatric examinations were made of the driver. Of those handled by the local police, the writer had the opportunity to make routine M.O. investigations of both criminal and traffic offenders.

The success of the M.O. in criminal investigation is based upon certain factors. The more important is a stereotyped form of behavior, which, in turn, is dependent upon personality factors, alcoholism, feeblemindedness, psychosis, psychosexual deviation, education, religious tendencies, et cetera.

About this time, Adolf Meyer and Hermann Adler, separately observing some of the Berkeley studies, later gave the writer opportunity to continue some of these studies—as research psychologist and later psychiatrist in the Illinois Division of the Criminologist where, at times, it became necessary to examine as many as two to 500 possible parolees a month and, under Meyer, to make exhaustive studies of types of offenders.

It was after the receipt of the following letter from Meyer that the writer decided to trace, according to subject material, some of the leading influences involved in such police forensic problems as the sexual and traffic offenders.

ADOLPH MEYER, M.D.
4305 Rugby Road
Baltimore 10, Maryland

April 22, 1947

Dr. John A. Larson
Arizona State Hospital
Phoenix, Arizona

Dear Dr. Larson:

Evidently you are in an interesting post, in which you might be able to give me some orientation as to the lay of the land. I am myself interested in making a kind of summing up of my perspectives, in which I should like to include wherein my Rush article heads towards a rejuvenation of a basic principle.

It is obvious that Rush was a kind of independent spirit, perhaps onesided in his sticking to his Edinburgh training. However, owing to the fact that he remained a bloodletter and not a worker on "the person," his objectivity remained anecdotal rather than what we now would like to develop into real personality studies. On the other hand, he used chance memories as more valuable to real contact with the patient, a method which did not rise to the objectivity based on personality study such as the one I hoped to cultivate and make the setting of the scientific—*and logical*—methodology which derived from our American philosopher Peirce, who inspired the historians, Robinson and William James and John Dewey and, I might say, even Bridgmen, the physicist. This evidently is what I had in mind when I wrote my contribution to the Education Conference of 1936, culminating in the discussion of "sense."

I feel that in the fundamental interests in the cause of an independent American perspective, we have something in common, and I should be grateful for a kind of naïve or factual account of the events of a life along the lines which you have sought out. I think I should find material which fits well into the philosophy of ergasiology in the sense of what a history of the word means to me and intends to suggest.

I should have liked to spend some time at Berkeley to learn what happened behind the superficial developments in the life of the contributors, rather than their doctrinal dogmas. When I met you at Berkeley, I was only remotely acquainted with Tolman, Kroeber, Ball, the MacFarlands, and the present group, Reichmann, Brunswick, and the other members of the philosophy of science group, and the untiring pathfinder, Dr. H. M. Evans.

I wish I could get you to reminisce and to let me have the lines of association that express themselves in that indefinable interplay of data—which I think reaches expression in this "Revaluation of Rush." I should deeply appreciate whatever you can revive in that residue that wakes up only in a mood of reminiscence.

With best wishes,

Sincerely yours,

(Signed) ADOLF MEYER

Psychopathic Clinic, Recorder's Court, Detroit, was founded by Dr. Jacoby in 1919. The work of tremendous importance carried on since this time preceded similar work in the Chicago Municipal Clinic of Hickson, Solomon, Rotman, and others; the Behavior Clinic of the Chicago Criminal Courts, similar clinics established by Oliver in Baltimore, by others in Cleveland, Bellevue Hospital, Pittsburgh, et cetera. Here in these clinics, all interested agencies refer cases contacting probation workers, police and court officials before or after arrest or conviction. In most of these clinics, the opinions submitted (as in prison-classification clinics) are advisory only but are followed in many instances.

The first published paper in this country dealing with an integrated clinical study of the traffic offender referred to Court was "One Hundred Traffic Offenders" by Raphael Theophile, M.D., LaBine, Alfred C., Flinn, Helen L., and Hoffman, L. Wallace, Psychopathic Clinic, Recorder's Court, Detroit, Michigan; *Mental Hygiene,* Vol. 13, No. 4., Oct., 1929. Reprinted by National Committee

for Mental Hygiene. Among their interesting results were (p. 7 of the reprint):

"As regards the occurrence in really significant degree of traits definitely handicapping in personal and social relations, the following were noted:

Markedly Inadequate and Suggestible	48
Lacking in Alertness	41
Emotionally Unstable and Impulsive	57
Excitable	26
Immaturity of Attitude and Response	14
Unreliable or Undependable	28
Egocentric	31
Lacking a Proper Sense of Responsibility	45
Actually Antisocial in Attitude and Tendency	3

"This gives a total of 293 handicapping traits for the whole group, or a hypothetical average of 2.9 per individual."

Again:

"As regards general insight into traffic regulations, as determined by perfomance in connection with certain specific problems and familiarity with traffic regulations, 43 per cent were noted as definitely unsatisfactory, with 31 per cent acceptable and 26 per cent doubtful."

The authors, also, found that fifty showed such delayed reaction time that this would interfere in actual driving. Of significant findings in the summary, the following are noted:

"12 were definitely feebleminded.
42 were classified as of inferior intelligence.
1 was psychotic or insane.
1 showed an active epileptiform tendency.
46 were seriously handicapped by alcoholism.
2.4 was the median number of previous difficulties.
13 were acceptable as drivers on a liberal evaluation."

Many of these offenders were seen routinely by the writer (assistant director of the Clinic 1936-42). It was during this time that Alan Canty (then psychologist and now executive director) of the Clinic (Psychopathic Clinic of the Recorder's Court of Detroit), established the traffic division, introducing psychophysical tests, which for years he had used in the examination of employes or the Cleveland Street R.R. In addition to the usual physical, psychological, and psychiatric examinations, the following tests were included:

Depth Perception
Glare Sensitivity
Eye Tests
Color Vision
Perimetric Vision
Judgment of Speed and Distance
Reaction Time
Miniature Highway
Traffic Laws
Road Test by the Police Department

Canty summarized some of his findings in "The Case Study Method of Rehabilitating Drivers," *Journal of Social Psychology,* 12:171-278, 1940; received in the editorial office April 18, 1939. He presented this data at the annual meeting of the American Psychological Association held in Columbus, Ohio, September, 1938. Canty selected 500 cases for analysis.

Canty found (p. 272) upon using a control age group of drivers, non-clinic cases, the figures show that while 5 per cent of these 4093 Michigan drivers were over sixty years of age, only 2.4 per cent of our clinic cases were in this same classification. Also, the largest number of cases in each tabulation is between twenty and twenty-nine years of age. However, a greater percentage of clinic cases are in this age range than in the larger group—the comparative figures being 36 per cent for the clinic cases and 28.59 per cent for the control group.

In comparing these two groups, Canty found that the younger group had greater educational advantages—high school and college. Comparing the results of intelligence tests, he found (p. 273):

"Among the younger individuals, we learned that a predominantly large percentage are in the average section. This is not true among the 320 offenders; and again we found that there are a larger percentage of the younger individuals in the superior and very superior groups than is the case when considering older violators. Most remarkable is the fact that 41.25 per cent of the 320 group is feebleminded as compared to 26.67 per cent of the younger individuals. For the 180 cases the median I.Q. is 83 with a range from 43 through 122. For the 320 section, the median I.Q. is 75, with a range from 31 through 119. For the 500 cases as a whole, the median I.Q. is 77 with a range from 31 through 122."

Canty, also, found that in fifty-one of the 500 cases, alcoholism had been "the major or a contributing factor towards the patient's social maladjustment." He, also, found that 131 cases or 26.2 per cent were suffering from serious physical deviations. Hypertension, syphilis, and generalized arteriosclerosis formed seventy-six of this group; cardiac, hyperthyroidism, and epilepsy constituted another fourteen; eleven of the total group were actively psychotic, and eleven showed other psychiatric defects.

Lowell Selling, M.D., presented Canty's tabular

findings in three of the tables (acknowledging credit to Canty) in a brief paper read at the annual meeting of the American Psychiatric Association, May, 1939, and published in the *American Journal of Psychiatry,* Vol. 97, No. 1, July, 1940. His usage of the Intelligence Quotient material is rather confusing as he only refers to the total group and does not show the important age differences found by Canty. Dr. Selling described two cases, given him by Detroit psychoanalysts, Dr. Harry August and Dr. J. Clark Moloney, in which compulsive-impulsiveness apparently played a role —in one instance driving into persons in a safety zone, the other instance running into traffic policemen. Fortunately, then, Canty's findings of 500 cases were presented before the two major groups within a few months of each other.

Some nine years later, a paper* covering the same problem was presented at the May, 1949, Annual Meeting of the American Psychiatric Association held at Montreal. Here, the emphasis of the discussants was primarily psychoanalytical. Dr. Selling referred to his work when a member of the Clinic in Detroit. He spoke of the existence of a psychosis found in traffic offenders—Parapsychosis A and B—although his findings have never been confirmed.

Role of Epilepsy, Electroencephalic diagnosis and Legislation

While giving a two months' course (1939-40) to the ranking police officers of Honolulu, where I instructed the class in case study, reports and criminological diagnostic methods, examining police clinical material at the Queen's Hospital in the morning and presenting the material in a two-hour class in the afternoon, and later in 1944 evaluating the work of the E.E.G. with a Los Angeles neurosurgeon, Mark Glasier, it was emphasized that forensic test results—chemical, deception, drug tests, et cetera—were not diagnostic alone but had to be integrated into a complete psychiatric analysis. In 1944, the writer was assisting in the evaluation of 100 questionnaires returned to Dr. Glasier by leading U. S. neurologists. This work was precipitated by the problem raised as to whether the results of an electroencephalic examination alone would warrant diagnosis of epilepsy, so that predicated upon this finding under California statute the driver's license could be revoked. Carter, W. E., and Harvey, R. W., described this law in "Epilepsy—A Reportable Disease," *California State Department of Public Health Weekly Bulletin,* 18:28, (Aug. 5) 1939. Himler, elsewhere, discussed this general problem aside from that of diagnosis in "Epilepsy As A Traffic Hazard," JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, September, 1941.

The California law requires revocation of a driver's license following a convulsive episode. It was then necessary for the driver to have neuropsychiatric treatment and a letter before his license could be returned to him. The question raised by some California officials was whether an electroencephalogram could be taken routinely and the diagnosis made upon this alone so as to affect the legal status. The writer's opinion, based upon the answers to the questionnaires, was that the interpretations of the test results alone were not decisive as far as any legal action is concerned but must be supported by history and other clinical findings.

Released State Hospital Patients as Driving Hazards

Many states require a statement from the driver as to whether he has ever been a patient in a mental hospital. In some instances, as in California, a fingerprint check is required. In this connection, Himler wrote, "The provisions of practically all the forty-eight states possess operators' license laws which include some type of restriction against individuals who are unfit to drive. Michigan's Act 91 of 1931, which is patterned after the so-called Uniform Motor Vehicle Operators' and Chauffeurs' License Act, expressly prohibits licensing anyone who is 'afflicted with or suffering from such physical or mental disability as will serve to prevent such person from exercising reasonable and ordinary control' while operating a motor vehicle upon highways. License is also withheld from any person who has been adjudged by the courts to be 'insane' or an 'idiot, imbecile, epileptic, feebleminded' and who has not been restored to competency by judicial decree. Even then a driver's license is not granted unless and until the department given the responsibility for issuing licenses is satisfied that the individual is capable of operating a motor vehicle with safety to persons and property."

The problem presented by the discharged mental patient has not been dealt with in any of the

*"The Accident Prone Automobile Driver," W. A. Tillmann, M.D., and George E. Hobbs, M.D. Discussed by Lowell S. Selling, M.D.

papers discussing traffic offenders, except stating that the committed patient must be restored to competency. Himler, in the above reference, gives this more attention than others.

State laws may differ as to the type of discharge and the manner in which this may be secured, and, as in the Indiana State Hospital at Logansport, there may not be over five or six per hundred who are given a restoration to mental health yearly. No problem is presented by the patient on furlough or parole in most states, as far as the principle of not allowing a driver to have his license while on parole is concerned. However, in reference to the types of discharges in Indiana, restoration of legal rights must be through court ation in all cases regardless of type of discharge. It should be possible as in other states, for all patients who are given a discharge from a state hospital or from a commitment to have their legal rights restored. The exceptions should be in cases such as mental defectives and others who may be obviously incompetent but who may have recovered from their acute episode, but who will require the appointment of a guardian. This includes the present, unpsychiatric condition for discharge, "incurable and harmless." This classification is foreign to all psychiatric principles and should be abolished.

Those of us who have been most actively connected with traffic problems of police psychiatry, not in the court clinic, office, or institution, but from field contacts, know that the problem of the mentally ill driver is much more acute than is commonly recognized and has many ramifications. Many states will bar the epileptic, the actively psychotic, and the committed patient. There is some disagreement about the feebleminded—one psychiatrist insisting that the feebleminded make the best drivers. Such a statement is contrary to ordinary common sense, much less formal psychiatric principles. It is too late after the patient—furloughed or discharged—has killed to do much with him except what intelligently should have been done before. Many discharged patients are going to have relapses. There is no reason why these patients cannot be just as carefully scrutinized as epileptics, who in some states can have their licenses returned after they have been without seizures for two years. How are these patients to come before the attention of the state traffic motor vehicle departments? If this is done, what about privileged communications This latter question has been succintly discussed by Monrad Krohn (in Himler's paper) and is not of such importance that it has interfered with the forced reporting by the physician of patients with epilepsy or the reporting of communicable diseases. Naturally, any information given must be treated confidentially. In the cases of committed patients there is not the objection as in the case of the private physician who might raise the barrier of privileged communication to the reporting of a condition in the course of his private practice after the patient has solicited his help without this condition having been detected following a seizure while driving, et cetera. In the first place, all commitments are publicly recorded and access may be secured to the papers by anyone. Secondly, public official action has to be taken in some states, as in Indiana, before release, including both discharge by the superintendent and court action. Then, again, the public is entitled to the protection that can be secured by psychiatric recommendations given confidentially to the motor vehicle department with each discharge. The stipulation is that this information is confidential for official use only. If the suggestion is followed, before the refusal to return the license is made, the driver is referred to his own physician or psychiatrist, who may find him able to drive or request a period of supervision before the license is restored.

Aside from the obvious physical contraindications—deafness, marked visual disturbances, paralysis of such a nature as to interfere with judgment or physical manipulation of the car, night blindness, marked disturbances in reaction time (not infrequent with the feebleminded)—there are certain recurrent hazards which are not eliminated by the mere discharge of a patient from the committed hospital. Regardless of academic wranglings as to etiological causation of schizophrenia, as types, and especially the manic-depressive groups, we know that there may be recurrences anytime. These groups warrant psychiatric or other observation as much as the epileptic (also the tabo-paretic or paretic groups, in which convulsions or cardiac collapses may occur without warning). In securing an opinion from leaders as to the type of coma-insulin preferred, the etiologic bias could be seen in some. These only saw value in that insulin therapy in the different stages of coma might cause the patients to produce fantasy or other material later to be used psychotherapeutically. One enthusiastic analytical group, in attempting to explain the beneficial effects of elec-

tro-convulsive therapy, spoke of the experience being of value because it was received as a death phenomena by the patient. Even if primarily of psychogenic origin, with which the writer and those who have seen many patients—living, during necropsy, laboratory results, or viewing the "wet-brain" during psychosurgery—cannot agree, there is such a variance of symptomatology which would make the patient a dangerous driver. If, on the other hand, we consider schizophrenia as organic in character—whether due to endocrinological, allergy, virus, bacterial, or a combination of all—we can then envisage the now questionable nosological groups—catatonic, paranoid—as being but various stages of the same disease. The symptoms vary with the amount of organic damage, character—whether irreversible, et cetera. Naturally, psychogenic factors and psychotherapy are important; especially environmental factors needed in rehabilitation after any form of drastic therapy which, at least, makes the patient temporarily more therapeutically accessible. These same factors or problems are present with other organic brain conditions, cerebral arteriosclerosis, paresis, et cetera. Some years ago when at Baltimore, a friend and former colleague, Paul Schilder, gave the writer his book on the psychotherapy of general paresis. One of the writer's first intensive cases in 1928 was a manic patient (manic-depressive category) who in his precommitment frenzy drove recklessly at top speed until a catastrophe occurred. In Arizona, a little over a year ago, a patient (diagnosis, schizophrenia, simple type) was transferred to the Veterans Hospital from the Arizona State Hospital and, while released on a visit, drove at top speed through a stop sign into a bus, killing six including himself.

On several occasions, Mr. Travis of the Arizona State License Bureau asked advice about former patients. The risks, especially of paretics, were pointed out, and it was advised that before granting restoration of license, the prospective driver be examined by a physician, preferably a neuropsychiatrist. The terrific risk of chronic alcoholics was pointed out. In one instance, it was necessary to discharge such a patient who had been committed for a thirty-day period of observation only. He was placed upon a bus going to New Mexico. He got off, became drunk, stole and wrecked a car. This case could be multiplied. Not long ago, a patient was committed to the Logansport State Hospital. This man had had previous drunken driving charges against him and prior to this commitment had threatened to kill officers.

Finally following the suggestion of the writer, then superintendent of the Arizona State Hospital, Mr. Travis requested that the state hospital supply his division with the names of all patients when finally discharged. This matter was referred to the Hospital Board, but the request was denied. Months later, the writer, now superintendent of the Logansport State Hospital, received letters from Mr. Mahlon Leach, division director, and Mr. B. B. McDonald, assistant director, Bureau of Motor Vehicles, Division of Safety Responsibility and Driver Improvement. The writer answered these requests by submitting a psychiatric impression of the discharged patient, as far as driving hazard was concerned, to the Hospital Board of Trustees and the Indiana Council for Mental Health. The Board Members unanimously agreed, as did the Council, that the information should be submitted to the Bureau of Motor Vehicles. (See letters below from the Bureau of Motor Vehicles and the Indiana Council for Mental Health):

BUREAU OF MOTOR VEHICLES
State of Indiana
Indianapolis, Indiana
July 26, 1949

Dr. John A. Larson, Supt.
Logansport State Hospital
Logansport, Indiana

Dear Dr. Larson:

The law under which the Bureau of Motor Vehicles operates provides how drivers' permits and licenses are issued. Section 47-2704, BRS 1933, 1940 Replacement, Acts of 1945, Chap. 304, Page 1308 sets out the persons not to be licensed. This section provides as follows:

"The department shall not issue any license or permit hereunder: (d) To any person who has previously been adjudged insane, feebleminded, or an idiot, imbecile or epileptic and has not at the time of application been restored to competency by judicial decree, or released from a hospital for the insane or feebleminded upon a certificate of the Supt. of such hospital that such person is competent, nor then, unless the Commissioner is satisfied that such person is competent to operate a motor vehicle with safety to persons and property."

In order for the Commissioner and the Bureau of Motor Vehicles to better carry out the mandate of this Act, would you kindly furnish this office your certificate of the persons released from your institution as being restored to competency.

We would appreciate such a certificate from January 1949 and from month to month thereafter.

Very truly yours,
(Signed) B. B. McDonald
Assistant Director

BUREAU OF MOTOR VEHICLES
State of Indiana
Indianapolis, Indiana
August 8, 1949

Dr. John A. Larson, Supt.
Logansport State Hospital
Logansport, Indiana
Dear Doctor Larson:

As you know this Agency is charged with the responsibility of issuing driver's license and registrations.

Contained in the driver's license application is the following question: "Have you ever been adjudged insane or confined to an institution?"

Applicants for license who have been so confined or adjudged, frequently answer "no." It would be most helpful to the Commissioner, if upon release of any inmate from the institution the Superintendent thereof would notify this Agency of this fact and also whether or not in the opinion of the Superintendent, such inmate released is competent to hold driver's license.

Should the Superintendent see fit to co-operate with the Agency in this matter in the interest of public safety, all such information will be placed and held in absolute and strict confidence.

May I hear from you? With kindest personal regards, I remain

Respectfully yours,
(Signed) MAHLON LEACH
Division Director

* * *

INDIANA COUNCIL FOR MENTAL HEALTH
RADIO CENTER
INDIANA STATE FAIRGROUNDS
INDIANAPOLIS 5, IND.
September 15, 1949

Dr. John A. Larson, Supt.
Logansport State Hospital
Logansport, Indiana
Dear Doctor Larson:

The Council, yesterday, agreed with your Board that there is no objection to providing the Bureau of Motor Vehicles with your certificate of the persons released from the Logansport State Hospital who have been "restored to mental health" or "sufficiently recovered to be released."

Yours very truly,
(Signed) ARTHUR G. LOFTIN
Acting Director

* * *

DIVISION OF SAFETY RESPONSIBILITY
& DRIVER IMPROVEMENT IN DEPT.
OF BUREAU OF MOTOR VEHICLES
Room 148, State House
Indianapolis, Indiana
February 15, 1950

Dr. John A. Larson, Supt.
Logansport State Hospital
Logansport, Indiana
Dear Sir:

In answer to your letter of February 8, 1950, please be advised that letters which submit information as to your opinion of the hazards of a discharged patient's driving abilities is made confidential.

In the denial of applications for current driving licenses because of lack of sufficient proof of mental competency, these applicants are not advised to contact the institution in which they were a patient except in cases where there has been no prior legal adjudication of unsound mind.

Clearance cannot be had by examination of a private physician, but a legal adjudication of restoration to sanity is necessary in the case of those applicants who have previously been adjudged of unsound mind because of lack of capacity to make the proper affidavits, etc.

Enclosed herewith is a form letter which this agency attaches to all denials of applications.

Your interest and co-operation is greatly appreciated by this agency.

Respectfully yours,
LARUE LEONARD, Division Director
By: (Signed) CHARLES H. MAINS
Hearing Agent

* * *

STATE OF INDIANA
INDIANAPOLIS 4

Method of establishing proof of mental competency for purpose of obtaining a license from the Bureau of Motor Vehicles:

1. Any person having been adjudged of unsound mind by a Court of competent jurisdiction, whether committed to a mental institution or not, must obtain and furnish to the Division of Safety Responsibility, a certified abstract of record of the judgment or decree in which the party was found restored or recovered to sound mind. Such abstract of Court record can be obtained at the office of the Clerk of the Court.

2. Any person who has not been adjudged of unsound mind by a Court, but has been admitted or committed to an institution, must obtain and furnish to the Division of Safety Responsibility, a statement from the institution that such person has been discharged as recovered and will not endanger public safety upon the highways.

3. Any person who has not been adjudged of unsound mind by a Court, but has been admitted or committed to an institution, and who cannot obtain a statement from the institution as required in Section 2 above, must obtain and furnish to the Division of Safety Responsibility the statement of three (3) medical doctors that such person has recovered his mental competency and will not endanger public safety upon the highways. These statements must be accompanied by an affidavit of the applicant showing the inability to obtain the statement from the institution and the valid reasons for such inability.

4. Any person who has not been adjudged of unsound mind by a Court, but has been admitted or committed to an institution, and who cannot obtain a statement from the institution as required in Section 2 above, may, upon written application, have a hearing in the County in which he resides; at which hearing, he, as moving party, may present on his behalf, the testimony of a substantial number of reputable citizens of his com-

munity who believes he has recovered mental competency and will not endanger public safety upon the highways."

The present procedure at the Logansport State Hospital is that in the routine staffing of all patients for final discharge, as soon as the staff agrees on a discharge, a letter is dictated by the clinical director giving the type of discharge, diagnosis, and opinion as to driving hazard. These patients, especially certain groups, should have the same supervision that other discharged organic cases receive—epileptics in some states. Before the license is restored, the patients should be referred to a physician, selected by them, who should give them any necessary supervision, including treatment for seizures, observation, et cetera. They should be cleared by the physician before the license is restored. In all cases, the hospital recommendations must be kept confidential by the State License Bureau. The following is a tabulation showing the diagnosis, psychiatric prognosis, and driving recommendation of 161 cases discharged from the Logansport State Hospital in 1949:

Diagnosis

Schizophrenia all Types	58
Manic all Types	32
Senile Psychosis	4
Psy. with Cerebral Arteriosclerosis	7
Involutional Psy	11
Psy. with Convulsive Disorders	11
Psy. with Syphilis	7
Psy. with Alcohol, all Types	14
Paranoid Conditions	3
Mental Def	3
Psychoneurosis, all Types	6
Post Encephalitis	1
Psychopathic Personality	3
Psy. Assoc. with OC of CNS Deaf Mutism	1
Psy. due to Drugs	1
Primary Behavior Disorders	1
Without Psychosis	1
TOTAL	161

Psychiatric Prognosis		*Driving Recommendations*	
Good	5	Good Risk	5
Fair	14	Fair Risk	12
Questionable	4	Questionable	6
*Poor	137	*Poor Risk	137
*Very Poor	1	*Very Poor Risk	1
TOTAL	161	TOTAL	161

*Should not drive.

In some states, a discharge from the state hospital as "sufficiently recovered to be released" automatically restores the legal rights and status of the patient. Here, in Indiana, most of the discharges are not marked restored to mental health, but "sufficiently recovered to be released." It is necessary for the court to restore the patient to sanity. The hospital superintendent can have no interest in these proceedings. Conferences are being held by officials with representatives of the state's Attorney General's Office so that the discharge from the hospital *per se* will be enough without the patient having to resort to judicial procedure.

In Detroit, all patients are referred to the Traffic Clinic for examination before their licenses can be restored.

There is no reason why the state licensing department cannot benefit by psychiatric examinations based upon daily observations extending over long periods of time. With the discharge from the hospital, a letter can be mailed to the Motor Vehicle Department giving the opinion of the staff as to the advisability of the patient driving. A hospital discharge does not mean that the patient is a safe driver. He may never have had adequate mental health; he may be epileptic, feebleminded, crippled in some way. He may have had an acute episode—the cause for which he is committed to a state hospital—recover from this so that he can safely adjust in the community. Again, a paretic, schizophrenic, or manic-depressive patient may have remissions and be paroled with the possibility of a relapse.

Granted that few are approved for driving, the fact remains that some, if not many, of these patients may have relapses. By keeping these potentially recurrent psychotic patients from the wheel, thousands of accidents resulting in the loss of money, lives, damage to property may be saved.

Ideally every patient discharged from a mental commitment should have a certification as to driving. This should be independent entirely of any legal procedures as far as restoration to sanity is concerned. Upon the basis of this, the license should be withheld. In selected cases, the patient may appeal to the licensing department and submit to psychiatric examination. This should be of such importance that a psychiatrist should be available—whether centrally located or in the form of a mental clinic.

The Detroit Traffic Clinic has demonstrated the value of these examinations. There are not over a half dozen clinics giving routine traffic examinations as in Detroit. Many communities cannot, at least yet, finance or man such clinics. Yet daily thousands of patients with adequate psychiatric observation and diagnosis are being released.

During a police psychiatry meeting, Mr. Canty,

executive director of the Psychopathic Clinic, of which the traffic clinic is an adjunct, Recorder's Court of Detroit, planned to investigate the number of patients who had been committed to state institutions in the history of the Clinic. He will analyze these records and report in a subsequent convention.

Modus Operandi or the predictability of success or failure of the offender, accident-prone drivers, et cetera, is based upon a stereotype of behavior often found, present in all, but of special importance among offenders.

Because of a certain, often differential, habitual activity noted among criminals (years before any psychiatrists ever called attention to this phenomenon) police officials described the detailed manner of committing a crime; classified and disseminated this and were able to predict time and to apprehend the offender, although then unknown, by his M.O. (method of operating). Much can be done in the study of offenders merely by the correlation of the M.O. factors at the time of the accident or crime with personality factors available after his apprehension. In this way it is possible to explain why one criminal acts in a given way. His M.O. is predicated upon all possible personality factors, including habitual responses, education, intelligence, hostilities, et cetera. After personally, as police officer for four years, seeing how revealing the analysis of the M.O. could be, the writer for years later in his forensic contacts as research psychologist, and later as forensic psychiatrist within penal institutions, court clinics, community clinics, and institutions (private and public), studied these problems. Later sociologists, working in court clinics and within prisons, selected accident-prone drivers and those criminals who would fail or succeed upon probation or parole. Because of this ability, sociologists serve as actuaries in the Illinois prison system, making their predictions upon prisoners coming up before the Parole Board. The methods of the sociologists were statistical, not individual in character, and usually based upon weighted factors. They would point out after a summary of their findings that the individual had 80 per cent chances for success or failure, et cetera. They would use the psychiatrist's diagnosis as one weighted factor alone and often attenuate the value of this as a prediction factor. The psychiatrist, however, after an analysis of all the given factors, objectively considered, unweighted, would make a definite individual prediction in many cases. Both methods of prediction revealed a high ratio of success.

In making his predictive analysis, the writer would integrate the evaluation of the M.O., crime incidents, behavior at the scene of the accident, or commitment allegations with the entire psychiatric history and all examination results. (See papers, "Prediction of Parole Success or Failure by the Prison Psychiatrist," read at the annual meeting of the American Prison Congress held in Baltimore, 1931; "The Prison Psychiatrist, A Statistical Analysis of Over 15,000 Prisoners," read at the annual meeting of the American Psychiatric Association at Philadelphia, 1932; "The Modus Operandi and Personality Studies of Homicide Offenders," read at the annual meeting of the American Psychiatric Association held in N.Y.C., 1934; "Modus Operandi and Personality Studies of Sexual Offenders," including pictures and an analysis of Goodrich, whose crime was responsible for the Sex Act of Michigan, read at the annual meeting of the International Association of Identification Experts held at Dallas, Texas, 1936; "The Modus Operandi as a Psychiatric Method of Securing Rapport," read at the annual meeting of the American Psychiatric Association, Pittsburgh, Pa., 1937; "Dactyloscopic and Psychobiological Integration," read at the annual meeting of the American Orthopsychiatric Association, N.Y.C., 1937; "The Modus Operandi and Personality Studies of Arson Offenders," a preliminary outline published in the *Michigan State Police Journal,* 1940).

Summary

1. A brief reference was made to the leaders or clinics pioneering in the examination of traffic offenders.

2. The average behavior or court clinic including criminal detection laboratories, police psychiatrists are not making routine examinations of traffic offenders.

3. Although many states prohibit driving of committed patients, nothing is done to protect the public from these patients driving, who after final discharge may still be dangerous as drivers. California has a special law relating to the epileptic driver.

4. The Indiana State Bureau of Motor Vehicles now is receiving opinions as to discharged state hospital patients. These opinions are confidential.

5. In all cases where it is known in any way

(Continued on Page 1311)

Impressions of Gout

By Fritz Bramigk, M.D., Ph.D.

Detroit, Michigan

THE STUDIES and impressions herein reported represent part of an intensive work on gout, none of which has yet been published. This work was stimulated by the observation that during my early years of medical practice in this country (beginning in 1925) I saw a surprisingly small number of patients with gout. Since my experiences in Europe had accustomed me to seeing numerous cases of gout during the year, I wondered whether there might not be some reason, environmental, climactic, economic, or social, why the incidence of gout in my practice had dropped so radically. Since it is generally accepted that there are phases of gout which are non-articular in manifestations, I wondered whether it might be that I was not recognizing the atypical forms of gout, or whether gout in the United States manifested itself ordinarily in different guise from the classical forms which have been described primarily on the basis of European investigations and publications.

Review of available literature on the problem of gout soon led to the recognition that constant repetition of concepts were handed down from textbook to textbook and accepted without adequate confirmation, and that frequently there was insufficient differentiation between gout primarily as a metabolic disorder, and gout primarily as an arthropathy. In addition, it was quite evident that much of the research on uric acid metabolism had been performed with too brief a period of observation. Many of the reports involved investigations which lasted only a few days. The effect of purine-containing foods was expected to be manifest within a day or two after the ingestion of these foods.

I felt that it would be wisest for me to approach the problem from an unprejudiced viewpoint and to make long range observations on uric acid metabolism. In view of unsatisfactory experiences with subjects who were hired for the purpose of study, and whose unreliability became apparent very early, I found it necessary to do most of the work upon myself. The first procedure was to establish my endogenous uric acid output. For this purpose, I lived on a purine-free diet for four and one-half months in 1931 and determined that the level of endogenous uric acid output for myself was 316 mg. per twenty-four hours. Determinations made of my serum uric acid concentrations varied initially from 6.4 to 5.0 mg. per cent. During the period of my diet, the level varied from 2.4 to 2.0 mg. per cent. Subsequent investigations on myself and others have convinced me that the average level of the endogenous uric acid excretion is closer to 450 mg. per cent or 500 mg. per cent. In a perfectly normal individual without any manifestations of the gouty diathesis (which I shall define later), I found that the level of the endogenous uric acid excretion was reached within a period of about three to five days after the initiation of a purine-free diet. Table I, which was obtained from such a normal control, is representative.

TABLE I. URIC ACID EXCRETION ON PURINE-FREE DIET IN A NORMAL CONTROL

Date	24-hour Urine Uric Acid Excretion
12/4/33	3,263 mg.
12/5/33	1,568 mg.
12/6/33	1,392 mg.
12/7/33	398 mg.
12/8/33	468 mg.
12/9/33	425 mg.
12/10/33	734 mg.
12/11/33	428 mg.
12/12/33	351 mg.

TABLE II. URIC ACID EXCRETION ON PURINE-FREE DIET IN A GOUTY INDIVIDUAL

Date	24-hour Urine Uric Acid Excretion
10/19/44	1,030 mg.
20	1,060 mg.
21	1,050 mg.
22	945 mg.
23	1,150 mg.
24	1,320 mg.
25	1,030 mg.
26	920 mg.
27	620 mg.
28	640 mg.
29	575 mg.
30	550 mg.
31	380 mg.
11/1/44	470 mg.
2	460 mg.
3	lost mg.
4	420 mg.
5	520 mg.
6	380 mg.

In contrast, Table II, which represents one of many series of studies upon myself, is a typical result in a patient with gouty diathesis upon a purine-free diet.

It was quite apparent that in my own case the delay in reaching the level of endogenous uric acid excretion was almost two weeks, as compared with the relatively rapid attainment of that level in the normal control. For a period of seven and one-half months in 1944-1945, I made daily

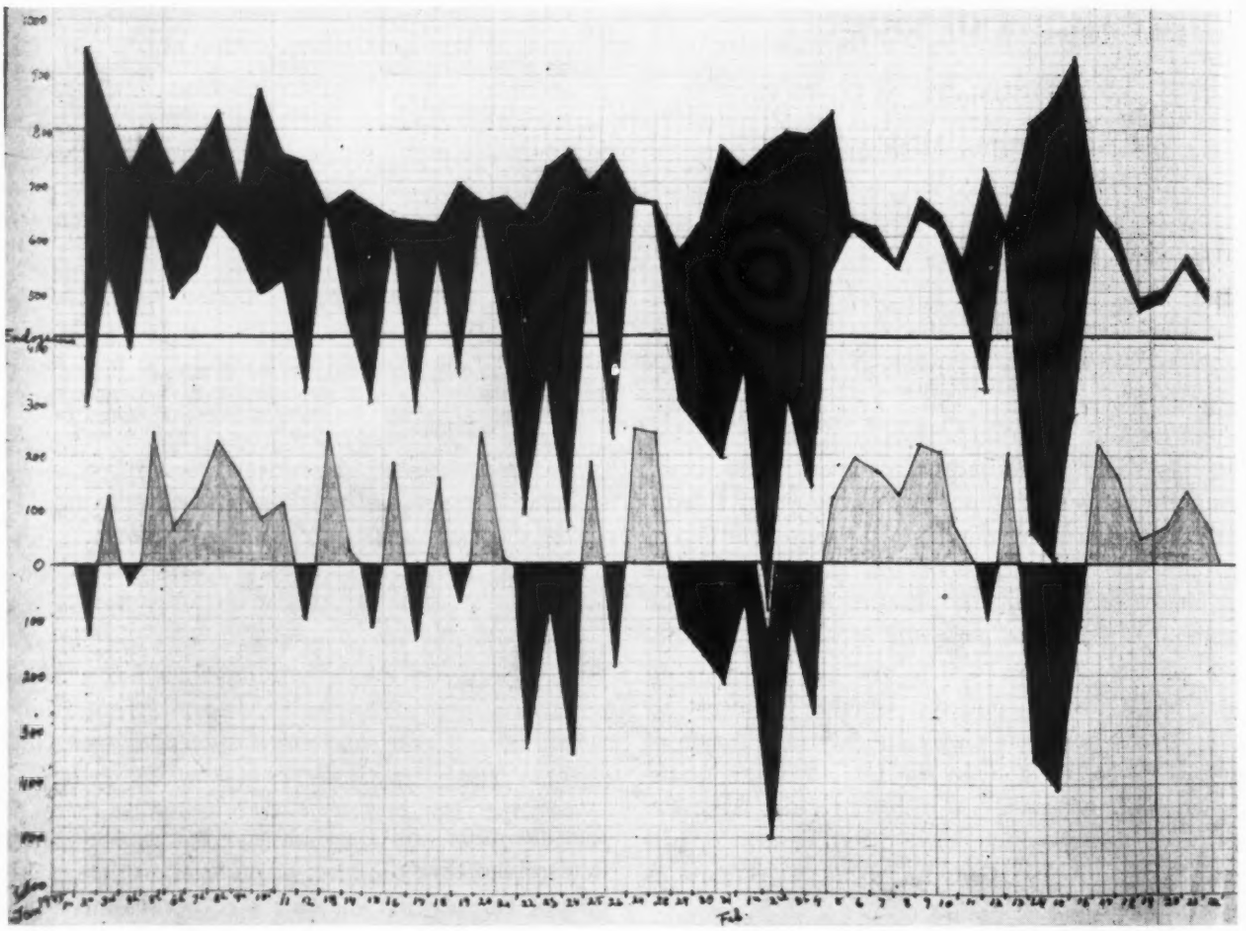

Fig. 1-*A*. The top of the shaded area indicates excretion of uric acid in each 24-hour urine specimen. The graph line starting at O when below O indicates the amount of uric acid to be considered as retained in the body. The graph line above O indicates the amount of uric acid excretion in excess of the total uric acid intake and endogenous uric acid.

measurements of my uric acid excretion, and calculated my uric acid intake in foods.[1] For a seven-week period on a purine-poor diet during this interval (with an average intake of 279 mg. of uric acid daily) my total intake of uric acid in the food in that seven-week period was 13.692 grams, while my urinary excretion of uric acid was 34.244 grams. The difference between these two figures, or 20.552 grams, represents the endogenous uric acid output during that interval, which came to approximately 420 mg. daily.

For comparison, on days during which my purine intake was higher, averaging 653 mg. of purines calculated as uric acid per day, my uric acid output in twenty-four hours during those days averaged 802 mg. The difference between these latter figures is approximately 149 mg., and the difference between this figure of 149 mg. and my average endogenous uric acid excretion of 420 mg. represents in essence a retention of 271 mg. of uric acid daily during this interval.

It must be noted that the intake of 653 mg. of uric acid per day during the later period which I have described represents a moderate and not a high intake of purine-containing foods. To illustrate further the significance of these findings, I have delineated in graphic form for a period of fifty-three days the following measurements:

1. The twenty-four-hour intake of uric acid (calculated from the purine-containing foods).
2. The twenty-four-hour total excretion of uric acid.
3. The amount of uric acid excreted beyond intake plus endogenous excretion (420 mg.) in twenty-four hours on those days when the uric acid excretion exceeded the total of uric acid intake plus endogenous uric acid excretion.
4. The amount of uric acid retained on those days when the total uric acid excretion was less than the sum of the uric acid intake plus the endogenous uric acid excretion.

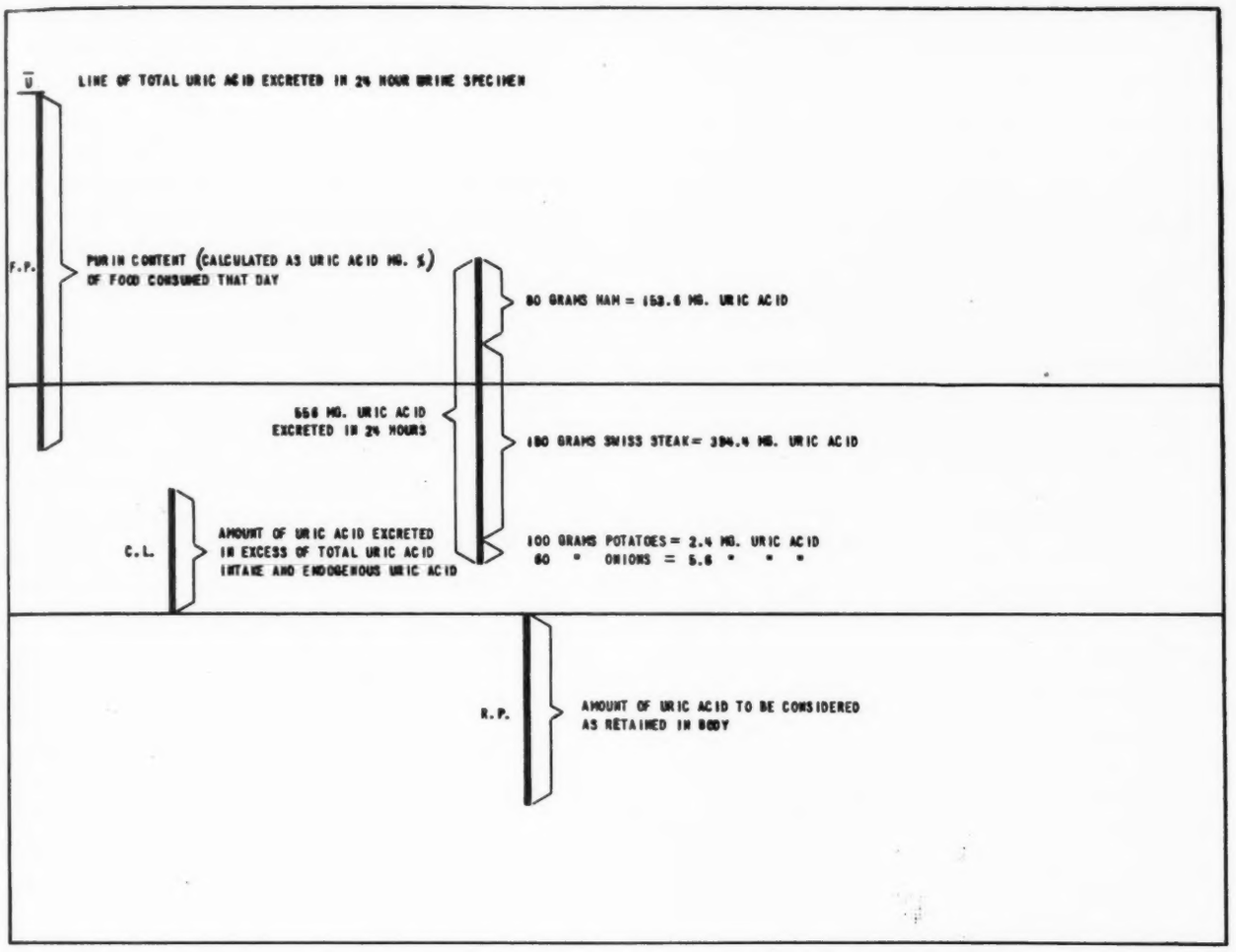

Fig. 1-*B*. For proper understanding, Figure 1-*B* should be superimposed upon Figure 1-*A*.

I should note parenthetically that during the periods of my dietary regulation and metabolic studies, attempts were made to control, as far as possible, such variables as activity, disposition, and other environmental factors. My weight during these intervals remained practically constant.

The volume of urine excreted in any twenty-four hour period bore no consistent relation to the amount of uric acid excreted in that period. Projecting the retention of 271 mg. of uric acid daily, as derived from the studies mentioned above, it is apparent that, other factors being constant, over a period of thirty years there would result an accumulation of about 6 pounds of uric acid in the tissues of the body. It is surprising to find occasionally at post mortem examinations of gouty patients, enormous deposits of urates in mesenchymal tissues.

It is my impression that this retention of 271 mg. of uric acid a day is not an excessive amount by any means. One sees so frequently at luncheon meetings men who fall asleep during the after-dinner speeches, even if the speaker is good, possibly partly as a result of excessive uric acid saturation. There is a structural chemical similarity between uric acid and barbital, and it was the observation by von Mehring that patients with high uric acid concentrations were so sleepy which stimulated Emil Fischer to synthesize barbital.

From observations and studies of this character made upon myself, upon normal controls, and upon patients with classical gout, I have arrived at certain impressions regarding the manifestations of this disturbance of purine metabolism. These impressions may not withstand critical scientific analysis at the present time. In the first place, they represent the result of studies upon a very small group of individuals. The limitations on the extent of study were necessitated by lack of facilities and lack of trustworthiness of hired subjects. I have attempted to compensate for the

few patients I have studied by investigating intensively the ones I was able to observe.

It is my impression that the picture which the word "gout" brings to the mind of the average

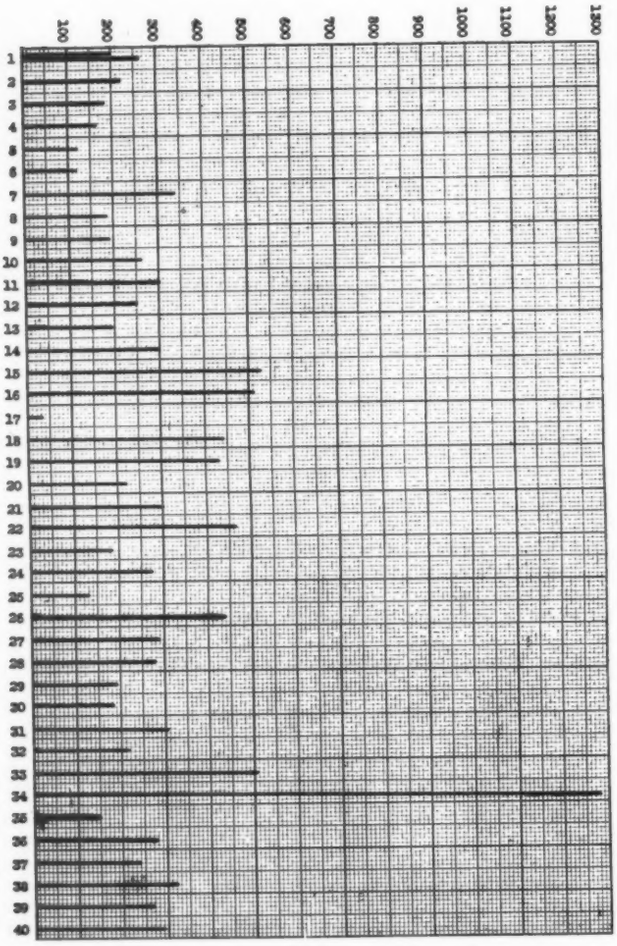

Fig. 2. Purine contents of 100 grams of food, calculated as uric acid mg. per cent. Taken from Table 58B, pp. 756-758 of Dietetics for the Clinician by Milton A. Bridges, according to McCane and Widdowson ("Chemical Composition of Foods," Medical Research Council, 1940).

1. Bacon, fried
2. Bass, steamed
3. Beefsteak, grilled
4. Beef, topside, lean
5. Brains, calves, boiled
6. Chicken, roasted
7. Cod roe, fried
8. Crab, boiled
9. Duck, roasted
10. Flounder, steamed
11. Goose, roasted
12. Haddock, fried
13. Ham, lean, boiled
14. Hare, roasted
15. Heart, sheep, roasted
16. Herring, fried
17. Irish stew
18. Kidney, ox, stewed
19. Liver, calves, fried
20. Lobster, boiled
21. Mackerel, fried
22. Mussels, boiled
23. Muttonchop, lean, fried
24. Mutton leg, boiled
25. Oysters
26. Partridge, roasted
27. Pigeon, roasted
28. Pheasant, roasted
29. Pork loin roast, lean
30. Rabbit, stewed
31. Salmon, canned
32. Shrimps, cooked
33. Smelt, fried
34. Sweetbreads, stewed
35. Tongue, ox, pickled
36. Trout, steamed
37. Turkey, roasted
38. Veal cutlet, fried
39. Veal fillet, roasted
40. Venison, roasted

For one bottle of beer the author estimates 80 mg. of uric acid.

physician is a relatively rare manifestation of this disorder. The acute, dramatic arthropathy, which is seen classically, and is so widely discussed in the literature of science, fiction and history, is by no means the exclusive nor the most common manifestation of this disorder, in my opinion. I have the impression, based on my experiences, that a good many of the vague myalgias, neuralgias, "lumbagos," "sciaticas," "muscular rheumatisms," "fibrositis," and a wide assortment of vague aches and pains in the muscles and joints of the body, plus ill-defined visceral manifestations, such as gastrointestinal disturbances and proctalgias, may actually be in many instances manifestations of gout in its broadest sense, meaning a disturbance of purine metabolism. It is well known and widely accepted that diverse renal lesions may accompany gout. The incidence of hypertension and arteriosclerosis in gouty patients has been demonstrated to be higher than that in a normal population. The mechanism of the disorder of purine metabolism is not clear. It has been suggested that retention of uric acid in the body may be due to interference with renal excretion of this substance. However, this renal function may be entirely normal in the gouty patient, at least as determined by the usual kidney function tests. Undoubtedly, in late stages of gout, complicated by advanced renal disease, uric acid retention enters the picture on a renal basis coexistent with azotemia but this mechanism does not apply in the vast majority of gouty patients.

From the studies similar to those described, I arrived at the conclusion that I represented an example of abnormal purine metabolism. I had occasional periods of mild arthropathy characteristic of so-called classical gout, associated with a few tophi, but I was also subject to the vague aches and pains described as neuralgias and myalgias and so forth. I noted that these episodes of discomfort coincided with periods of uric acid retention, and were relieved by strict attention to dietary restriction of purine plus occasional small doses of colchicum. During this period, I noted that the ingestion of wheat would lead to decreased uric acid excretion, and presumably uric acid retention. As an example, for a seven-day period in November, 1934, I ate a practically purine-free and wheat-free diet and excreted an average of 435 mg. of uric acid daily. During the subsequent four days, I ate a purine-free diet but included wheat, and my uric acid excretion dropped to an average of 319 mg. daily. On occasion, I found that the ingestion of wheat products, even when I was on a low purine intake, might lead to the development of myalgia, et

cetera. Skin tests for wheat sensitivity made by highly competent allergists were negative.

As a result of these experiences, I felt that the ingestion of wheat causes uric acid retention in my own particular case, presumably as a result of wheat sensitivity. When I restricted my food to a wheat-free and low purine diet, my symptoms entirely subsided and disappeared.

In studying my gouty patients I found many instances of wheat sensitivity as gauged by skin tests. In these patients, on repeated occasions, I have observed that a low-purine and wheat-free diet results in prompt relief of their gouty complaints. However, should these patients return to a wheat-containing diet in a few days, even if the purine content is kept low, recurrence of their difficulties was the rule; but in those instances where the wheat-free diet was maintained for three or more months, it was common to find that the patients had lost their wheat sensitivity at the conclusion of that period.

The recent work of Selye[2] on the general adaptation syndrome and the diseases of adaptation is too well known to warrant repetition here. As a result of my studies in gout plus my reading of Dr. Selye's monumental work, it is my impression that gout represents one of the diseases of adaptation. We are all aware of the obvious factors which play contributory roles in the etiology of gout, such as trauma, emotional disturbances, infection, weather changes and dietary indiscretions. My own studies lead me to believe that allergy, at least in many instances, also plays a contributory role, and furthermore, that the hereditary tendency in gout may well be due to the inheritance of allergy rather than the inheritance of a disturbed purine metabolism. In a patient with a constitutional disorder of purine metabolism resulting in accumulation of uric acid, possibly associated with a hereditary factor of allergy, the response to stress with resulting alarm reaction including lymphatic breakdown leading to further endogenous elaboration of purines, may lead to the accumulation of uric acid and other metabolites in tissue spaces with resultant precipitation of the symptoms of gout. The metabolites in the tissue spaces probably are retained therein as a result of vasospasm, and some of these metabolites probably correspond to the "P" factor of Lewis. The cause of the vasospasm is uncertain but may be related to concomitant disturbance of the autonomic nervous system or the hypophyseal-adrenal relationship.

Based on this concept, my management of a so-called gouty patient consists of the following approaches:

1. Prevention of uric-acid retention, including limitation of purine intake.
2. Search for, and elimination of, allergy as a contributory factor.
3. Persistent use of small doses of colchicum daily.
4. Avoidance, insofar as possible, of the contributory factors mentioned formerly.
5. Maintenance of the general physical and mental health of the patient.

Summary

1. Gout is a common disease, frequently missed because its manifestations are often atypical.

2. Disturbance of purine metabolism, with retention of uric acid, appears to be the primary mechanism involved. Studies are herein reported confirming the advisability of purine restriction in the management of gout. However, allergy may play a causative role in the retention of uric acid even with adequate dietary purine restriction.

3. The concept of gout as a disease of adaptation is briefly discussed.

References

1. Bridges, M. A.: Dietetics for Clinicians. Philadelphia: Lea and Febiger, 1941.
(Table on the Chemical Composition of Food from the Medical Research Council, 1940).
2. Selye, H.: The general adaptation syndrome and the diseases of adaptation. J. Allergy, 17:231-247, 289-323, 358-398, 1948.

MSMS

FSA has a budget, this year, of $1,591,000,000—larger than any department except National Defense—and 35,363 full-time and 4,127 part-time employes. It has 12 regional offices and many National Institutes of Health and Health Workshops in cities and towns. It administers Social Security which includes Public Assistance, Old-age and Survivors Insurance, the Children's Bureau, and Federal Credit Unions; Employes' Compensation; Public Health Service including quarantine and 20 odd hospitals; a printing house for the blind in Louisville; Food and Drug Administration; Vocational Rehabilitation, and the Office of Education. In Washington, it operates two big public hospitals—St. Elizabeths and Freedmen's—Howard University for Negroes, Gallaudet College and Kendall School for the Deaf.

Does Uterine Myoma Always Mean Operation?

By William F. Mengert, M.D.
Dallas, Texas

Incidence

UTERINE myomas have been known since antiquity but it was not until 1813 that they were identified as arising directly from muscle. There have been no recorded cases of myoma of the uterus prior to puberty. It is barely possible that some occur and remain unrecognized, because smooth muscle tumors of other organs; for example, stomach, and intestine are well known. Few myomas develop prior to the age of nineteen or twenty. Following the age of twenty-five they begin to grow and approximately 20 per cent of all women between thirty and thirty-five years old have myoma even though small. Obviously, the greatest incidence is reached just before the menopause because myoma of the uterus regresses thereafter and new ones don't develop. On most gynecologic services, myoma of the uterus will range around 4 to 5 per cent of gynecologic admissions. In any hospital pathologic service myoma will be found at autopsy in approximately one-third of adult negro women and one-tenth of white women.

Growth and Development

The blood supply of myoma is the all-important factor controlling growth and development, and explains many things about the tumor. Each nodule usually possesses one nutrient artery penetrating the pseudocapsule and going directly into the tumor. Otherwise there is transference of blood to the tumor from the capsule by capillary vessels. In consequence, the blood supply of myomas is generally poor. Another characteristic feature of uterine myoma is spherical growth. Because of local distortion this may not be true in some instances, but the tumor does tend to grow equally in all directions. As it grows, it pushes aside normal muscle tissue and never engulfs vital structures. The cells of the immediately surrounding normal muscle tissue are, therefore, compressed, become necrotic and fibrotic, and suggest a tumor capsule. Actually, myoma does not have a capsule, but a pseudocapsule, composed of these compressed and fibrosed cells. A myoma can be readily shelled out from its pseudocapsule, with minimal bleeding if one finds the correct line of cleavage. Otherwise, myomectomy is rough and bloody going. Myomas are somewhat dense to palpation. Generally, the consistency is harder than normal muscle. On the other hand, if degenerated, they may be so soft as to suggest pregnancy, or ovarian cyst. The uterus itself does not enlarge or develop along with the growth of the tumor. Only the tumor enlarges and thus, seemingly causes an enlarged uterus. This is, however, apparent only. Conversely, the uterus does not have to involute following myomectomy and therefore has good opportunity to heal.

Myomas arise from muscle tissue itself and apparently not from embryonic inclusions. They have no relation to parity and there is no apparent relation to general body nutrition. The idea of a growth energy theory originated with the thought that isolated cell bundles for some unknown reason, shake off the state of rest and proceed to grow. No report has been made of occurrence of myoma in women under the age of puberty, and we are all thoroughly familiar with the fact that when a woman with myomatous tumors reaches the menopause she will have no further trouble with the tumor unless malignancy develops. These facts gave rise to the idea that myomas are associated with, and subject to, the influence of estrogen. On the other hand, this is not true of myomatous tumors of other smooth muscle organs. Therefore, there is reason to believe that atrophy of the myoma at the menopause is not due to withdrawal of estrogen, but to the markedly diminished blood supply of the genital region of the postmenopausal woman. This is a secondary, and not a primary effect of the estrogenic hormone.

Types of Myoma

Myoma of the uterus may be classified as (1) cervical or corporeal, with about 8 per cent being cervical and 92 per cent corporeal; (2) in relation to the layers of the uterus. Since most of the bulk of the uterus is muscle you would obviously expect most myomas to be interstitial or intramural. This is true. Sixty to 70 per cent are intramural, 10 to 15 per cent are submucous, growing underneath the endometrium, and the remaining 20 to 30 per cent are subserous, developing underneath the peritoneum, with or without a pedicle (Fig. 1).

The submucous myoma obviously will cause

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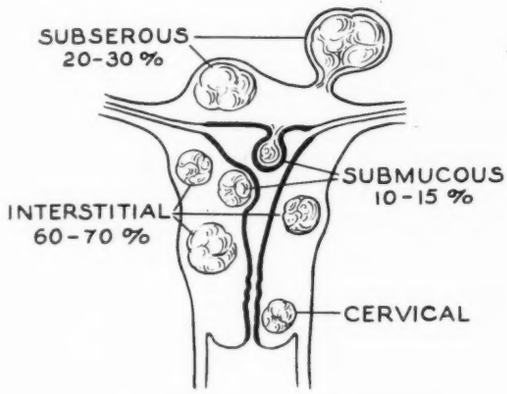
most trouble because it can interfere with fertility; it can distort the cavity of the uterus and interrupt pregnancy when it starts; it is associated with bleeding. When a woman with uterine myoma has



MYOMA, TYPES

Fig. 1.

menorrhagia, the chances are strong that she has a submucous nodule, or if not a submucous nodule, certainly one close to, or encroaching upon, the endometrium.

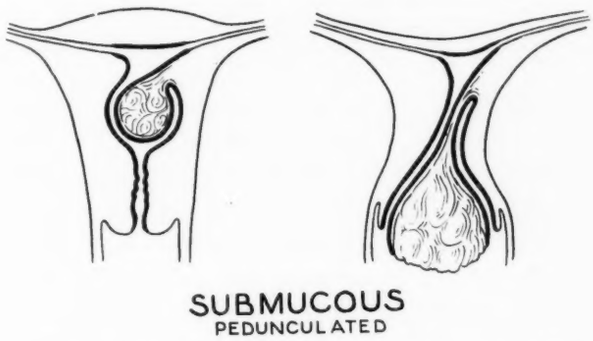
The subserous variety do not cause bleeding but, because they are often pedunculated, frequently give trouble by virtue of degeneration, twisted pedicle or dystocia in labor. Furthermore, it is the subserous type of tumor which produces the wandering fibroid, a pedunculated subserous tumor whose blood supply has become impaired. Because of this the surface becomes sticky and adheres to omentum, mesentery, gut or parietes. Ultimately, the tumor blood supply is derived from the secondary attachment and the primary pedicle withers and breaks.

Since myoma originates within the wall of the uterus, intramural fibroids, of course, are the parent of all types. Although intramural tumors can degenerate, there can be an astonishing number and variety without symptoms.

Symptoms

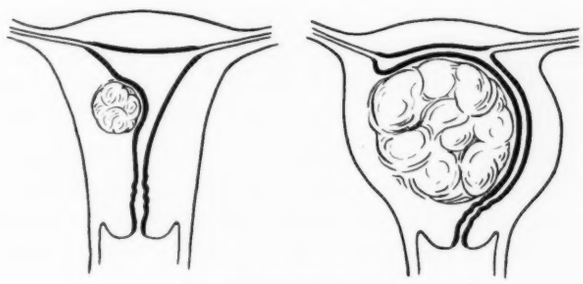
The symptomatology of myomas includes bleeding, discharge, pressure, pain and mass.

Dysfunctional bleeding is frequently associated with myoma. In fact, vaginal bleeding depends almost entirely upon associated phenomena and generally does not originate within the mass of the tumor. A patient seen a number of years ago illustrates this point. She appeared with the cervix about 4 or 5 centimeters dilated by a myomatous nodule approximately tennis ball in size. It originated from the corpus and had a long pedicle which was readily snipped off with the scissors.



SUBMUCOUS
PEDUNCULATED

Fig. 2. Note enormous enlargement of the surface area of the endometrium as the tumor grows. Not only will the endometrium bleed, but also the tumor can bleed directly from the raw area projecting into the vagina.



SUBMUCOUS

Fig. 3. Note enormous enlargement of the surface area of the endometrium as the tumor grows.

Six months after going home she returned, still bleeding. At this time total hysterectomy was performed, removing an anatomically normal uterus. With careful, visual inspection of the removed uterus it was impossible to see where the pedicle originated. This woman was bleeding, not from the myoma, but from a menstrual dysfunction (Fig. 2). Bleeding, as pointed out, depends almost entirely upon associated phenomena. On the other hand, if there is a big myomatous nodule just under the mucosa and the endometrium is stretched over it, the distortion of the endometrial cavity and the *great increase in the surface area of endometrium from which the woman can bleed* would certainly explain to some extent a greater flow than before (Fig. 3). The uterine cavity is normally a few square centimeters in extent. If there has been distortion of the cavity so that the surface area of the endometrium is many times increased, one would expect the patient to bleed more profusely with each mentrual period simply because she has

a potentially larger bleeding surface. Myomas do not bleed after the menopause. If a woman with a known myomatous uterus bleeds after the menopause, we must look beyond the myoma for the bleeding. Too many women have perished unnecessarily from cancer of the uterus because of lack of this knowledge. To repeat, women do not bleed from fibroids after the menopause.

Discharge from myomatous tumors is of secondary nature and usually arises from pedunculated submucous tumors which have become secondarily infected.

We must be very cautious about the symptom of pressure. I doubt that myoma ever causes pressure pain. Myoma can, however, cause pain, usually due: to interference with the blood supply, as so often happens during pregnancy; to torsion of a pedicle; or to infection of the nodule, secondary to diminished blood supply. Regarding the symptom of pain, remember that myomatous tumors possess no nerves except those accompanying blood vessels. Therefore, all of the symptomatology relating to pain from myoma must originate in the surrounding organs or in the blood vessels. For instance, when a myomatous nodule becomes infected and is exquisitely tender, the pain obviously comes from the overlying peritoneum and not from the tumor itself. Sometimes pain takes the form of uterine cramps, originating when the uterus attempts to expel a submucous pedunculated myomatous nodule as a foreign body. This can also be a rare cause of inversion of the uterus, although usually the myomatous pedicle will stretch sufficiently to allow the tumor to be extruded through the cervix.

The symptom of finding a mass is of interest. In this connection, one of the most interesting stories I know was concerned with a more than normally intelligent woman who awakened in the middle of the night with a full bladder, let her hand rest on the abdomen and felt a mass she had never felt before. She arose, voided, went back to bed, palpated her abdomen again and did not find the mass. She made the correct diagnosis; that there was some sort of tumor pushed upward and palpable only when the bladder was full. Actually, she had a myomatous tumor of moderate size, causing no symptoms except by its presence. A small myoma placed at a strategic anatomic position can cause much trouble. For example, one smaller than a golf ball but precisely at the bladder neck can cause inability to void and necessitate catheterization. I have seen a small myoma, embedded in the wall of the rectum, produce constipation. Pedunculated myoma sometimes causes obstruction to the course of labor. Here again it is not so much a matter of size as of the strategic position of the tumor.

Degeneration

Degeneration of myomas occurs as a result of diminished blood supply or vascular accident within the tumor. Degeneration can be cystic, hyaline, calcification, necrosis, myxomatous, infection, sarcoma and hemorrhage into the tumor. Cystic degeneration is sometimes highly confusing from the diagnostic standpoint. This is especially true when the abdomen is opened and the operator gets that sudden sinking feeling that perhaps he is about to operate on a normal pregnancy.

Treatment

Which myomas should be treated? Initially, we must accept a basic rule: *The mere presence of myoma is not indication for treatment.* The foregoing statement is true until the tumor becomes larger than the size of a three months' pregnancy, provided the patient's age is considered. In other words, I would not hesitate to institute treatment in a woman twenty years of age with a myoma of this size, and I would seriously hesitate to do so in a woman forty-five years of age with the same size myoma, providing both of them were symptom free. This is based upon the belief that the young woman has evidenced ability to grow myomas, and her chances of reaching the age of the menopause without ensuing trouble are far less than those of the older woman. Not only do tumors grow faster in younger women, but also the younger women have a longer time to grow them. Another reason for removal of large tumors, unless there is a constitutional contraindication to surgical treatment, is their likelihood to develop sarcomatous change. The associated malignancy is generally sarcoma because myoma develops from the embryonic middle layer and is not epithelial. On the other hand, there is statistically some evidence of association of endometrial carcinoma and myoma. Perhaps this association may be due to two things: (1) If estrogenic influence produced myoma, it could also produce adenocarcinoma of the endometrium. (2) A simpler assumption is that submucous myomas may so irritate the endometrium as to influence it to develop carcinoma.

Operation.—When it comes to operative treatment, what is the choice of operation? There are four operations for myoma. Myomectomy, subtotal hysterectomy, total hysterectomy and vaginal hysterectomy. Incidentally, virtually any myoma which can be removed abdominally can also be removed vaginally. I do not recommend it but it is a nice stunt to do once in a while, although the nodules must be taken out by morcellation. After both uterine arteries are ligated, one simply removes the tumors individually or piece meal until the total size is sufficiently reduced to permit hysterectomy.

Myomectomy is not as satisfactory an operation as hysterectomy. Obviously, if the uterus is removed there will be no recurrence, whereas if myomectomy is performed, small unrecognized cell nests will grow or tumors already started may be overlooked. The uterus has one and only one function in this world, and that is reproduction. To me the only reason for conservation when it has shown a propensity to grow myomatous tumors is preservation of the reproductive function. After the reproductive function has been satisfied, so far as that woman, her husband and her family are concerned, myomectomy does not seem to me to be a sensible operation.

There is no more reason to debate subtotal versus total hysterectomy with regard to uterine myoma than with regard to any other type of indication for hysterectomy. I believe in routine total hysterectomy.

Technical difficulties of operation come from size and position. But never forget that it is very simple to reduce the size of the myomatous uterus by myomectomy as a prelude to hysterectomy. A tennis-ball-sized myoma behind the cervix can interfere seriously with elevation of the uterus into the abdominal wound. Cut across the posterior peritoneum of the uterus transversely, pull out the tumor and the uterus will come up. Towel clips will pinch the uterine edges together or sutures or hemostats can be used to control bleeding. Broad ligament myoma requires special technique in order to avoid damage to the ureter. These tumors should be carefully shelled out, after opening the top of the broad ligament.

Irradiation.—What is the effect of irradiation treatment? It has a minimal, if any, effect upon the tumor but, of course, produces castration. The woman then goes through the atrophy of the menopause with resulting decrease in pelvic blood supply and, therefore, shrinking of the tumors. I was taught some rules about irradiation; some of them are true, some are not. The first: women with bleeding submucous myomas should not have radium implantation, because of the strong possibility of infection attending the necessary packing of the uterus. On the other hand, this potential danger can be avoided if external irradiation with x-ray, instead of intracavitary implantation of radium, is employed. If external irradiation is employed, it is a vital necessity *to ascertain before treatment* that the woman does not have adenocarcinoma of the endometrium. In other words, *dilation and curettage must precede external irradiation.* The second rule: A myomatous uterus larger than the size of a three months' pregnancy should not be irradiated. In general, this rule is true. Myomas are not directly treated by irradiation, as mentioned above. The change occurring after irradiation is a decrease by about one-third in size and results from the atrophy attendent upon the induced menopause, rather than from direct action on the tumor. Therefore, the tumor will not disappear. This is not noticeable with small tumors, but may be disfiguring with large ones. Moreover, sarcomatous degeneration is found more often in large, than in small, tumors. The rule concerning size is only partially true, since large myomas can be treated by external x-irradiation if failure to disappear entirely is unimportant and the woman will chance the possibility of sarcoma. On the other hand intercavitary radium implantation is contraindicated because of the technical difficulties of failure to deliver a castration dose to the ovaries. There is always the possibility that a large nodule may push an ovary so far away from the uterine cavity as to be beyond the sphere of influence of the radium focus.

Operation versus Irradiation.—Now, who should get irradiation treatment and who, operation? I think we must apply the same type of philosophy and thinking here that is applicable to functional uterine bleeding. A woman of thirty with severe functional uterine bleeding, whether or not she has a fibroid, should receive hysterectomy because it is a selective operation and does not castrate her. A woman of thirty-five should also receive operative treatment. Moreover, most women of forty, with five, six or seven years of ovarian function ahead of them should not be unnecessarily cas-

trated. On the other hand, as patients approach the age of the natural menopause, irradiation castration becomes less and less of an emotional shock and therefore more and more preferrable to the

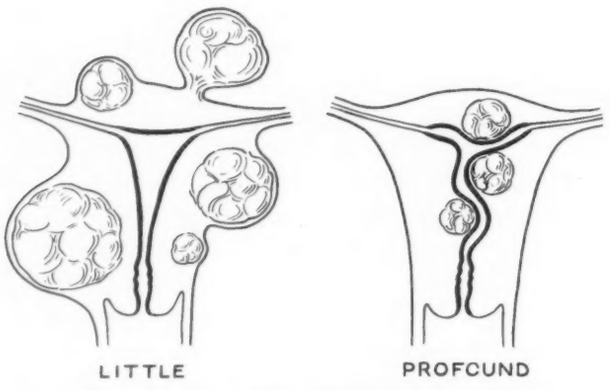


Fig. 4. Myomas disturb pregnancy when they distort and encroach upon the endometrium and the uterine cavity (*right*). The uterus may contain many tumors and successfully encompass a pregnancy if the tumors are external and do not affect the cavity (*left*).

physical shock of operation. In general, then, I would reserve irradiation for women at, or close to, the menopause when it is necessary that something be done for the myoma. Operation is reserved for the younger woman.

Relation of Social Factors to Treatment.—While we are discussing the question of age, let us also consider the effect of other social factors in motivating treatment. What would you do with a woman with a symptomless myoma the size of a small grapefruit? Let us consider four variants of this question. (1) What would you do if she were single, aged twenty-four? (2) What would you do if she were just married, aged twenty-four? (3) What would you do if she were thirty-four with three children. (4) What would you do if she were forty-four, irrespective of number of children? That is a most interesting question because nothing is different except age and maternal status. Before answering these questions, it is necessary that the examiner know specifically if a patient about to be myomectomized is in a position, and has the desire, to become pregnant. In other words, with a symptomless fibroid in a young girl who has no immediate prospect of reproduction, I should do nothing until she is prepared to undertake pregnancy. With a symptomless fibroid in a young, married nullipara I would perform myomectomy now. This woman has opportunity to become pregnant, she is young, has demonstrated her capacity to grow fibroid tumors, will grow more, or increase the size of the ones she has, and her chances of reaching the menopause without serious trouble are virtually zero. Such a woman should be told, after myomectomy, to become pregnant immediately. In the woman of thirty-four with three children, the obvious operation is hysterectomy. With the woman of forty-four, irrespective of family, if any treatment is necessary it should be irradiation because there is no sense in submitting her to the insult of a laparotomy when she has only a few years of menstrual life ahead. These are my personal views. Others may differ.

Myoma and Reproduction

Infertility.—Everyone believes that myoma and infertility are associated, although exact mechanisms are unknown. Perhaps women with myomas are prone to menstrual dysfunction, but whatever the cause, it is pretty well agreed that myomas are associated with infertility. Given a young woman, or rather a couple, on whom you have exhausted all of the tests for infertility, and the woman has a myoma, are you justified in recommending myomectomy? Although answers will vary, I believe the preponderance will be "yes." In other words, in the absence of other known causes of infertility it is justifiable to perform myomectomy on such a patient. After the patient becomes pregnant, and patients with myoma do become pregnant, there is always the question of abortion.

Abortion.—In general, when myomas do not distort the shape of the uterine cavity there is very little likelihood that they will produce abortion (Fig. 4). In other words, if there is bleeding associated with myoma in the nonpregnant woman the nodule is either submucous myoma or closely related to the endometrium. That is to say, the myoma is beginning to distort the endometrial cavity. In such an event, the likelihood of abortion increases with increased distortion of the cavity of the uterus. Moreover, with myoma directly under the endometrium the placenta has difficulty obtaining the blood supply essential for nourishment of pregnancy.

Differential Diagnosis.—There should be no great problem between diagnosis of myoma and of early pregnancy. Whenever a patient in the childbearing years presents herself with a midline

symmetric tumor the probability of pregnancy should always be borne in mind. Remember that while myomas can be hard in consistency, they can also be soft and cystic and thus counterfeit the pregnant uterus. In consequence, whenever there is a midline symmetric tumor of soft consistency it is virtually mandatory to do a biologic test for pregnancy before contemplating operation. As an alternate, and especially if there is no urgency, one may wait a month or six weeks because pregnancies increase rapidly in size during that time and myomas do not.

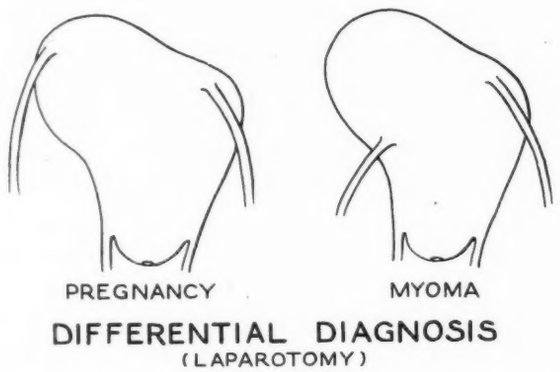


Fig. 5. Two identical situations seen at laparotomy. The round ligaments originate at the anatomic fundus of the uterus. Therefore, (*left*) there is a good chance the distortion is due to placental implantation whereas (*right*) the distortion is due to a myomatous nodule arising above the origin of the round ligaments.

At the time of operation, one is sometimes confronted with the all important question—myoma or pregnancy? Since the operator, standing at the table with the patient's abdomen already open, faces hard reality, it is highly desirable to make the most intelligent decision possible. In early pregnancy the uterus is frequently distorted because implantation has been on one or another side of the upper part of the cavity. This distortion can be mistaken for myoma. The clue to the situation lies in the round ligaments since these originate at the anatomic fundus of the uterus. Figures 5 and 6 clearly show how the relationship of the origin of the round ligaments differentiates between pregnancy and myoma in uteri which are otherwise identical in shape. Sometimes the myomatous uterus is symmetric, the round ligaments originate at the top, and decision is impossible. Then, the second step is to put a needle into the center of the mass. If the patient is pregnant, amniotic fluid will be obtained. If the myoma is solid, no fluid will be obtained. If however, the myoma has undergone cystic degeneration fluid may be obtained. In the last analysis you may have to sacrifice a possible pregnancy by opening the uterus in the midline and making a diagnosis by direct inspection. This method of making a differential diagnosis is not advocated. On the other hand, when because of a mistake the abdomen has been opened, it may be desirable to make a positive diagnosis at the risk of sacrificing the pregnancy. There are other possible hazards of myoma with regard to the process of reproduction and they include blocking of the pelvis by a pedunculated tumor, diminished uterine force, and delayed separation of the placenta. Although all of these can occur, most generally they do not.

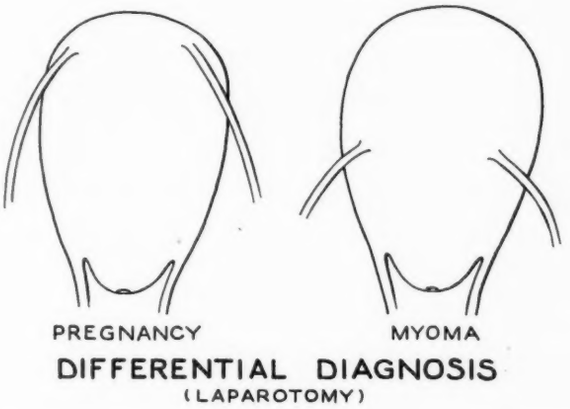


Fig. 6. Two identical situations seen at laparotomy. The round ligaments originate at the anatomic fundus of the uterus. Therefore, (*left*) there is a good chance the distortion is due to placental implantation whereas (*right*) the distortion is due to a myomatous nodule arising above the origin of the round ligaments.

Finally, it is desirable to say just a word about previous myomectomy. In general, a pregnant and previously myomectomized uterus is much stronger than a previously cesareanized uterus for the very obvious reason that healing after myomectomy takes place without the necessity for concomitant involution.

To sum up the matter of myoma and reproduction, it should be stressed that *by and large, the majority of women with myomas will become pregnant, will carry through to term without event, will give birth to healthy children, and will have no serious sequels.*

MSMS

It is estimated that about 25 per cent of solitary rectal adenomas become malignant.

* * *

The most common symptom in tumors of the larynx is hoarseness, which may be trivial or serious.

* * *

When a noticeable change in voice or a persistent hoarseness persists for a period of three weeks, cancer of the larynx must be suspected.

A New Antispasmodic—Bentyl Hydrochloride

Preliminary Experience

By A. Ray Hufford, M.D.

Grand Rapids, Michigan

A WIDE VARIETY of organic diseases and functional nervous conditions produce unpleasant symptoms largely or partly because of manifestations of smooth muscle spasm. Pain, cramps, diarrhea, constipation, nausea and vomiting are frequently manifestations of an abnormal increased tone or motility of the smooth muscle in the gastrointestinal, biliary, or genito-urinary tracts. Relief of such symptoms with the aid of antispasmodic drugs is frequently most useful in that it makes the patient comfortable during clinical investigation, while more fundamental therapeutic measures are being instituted to relieve an organic or psychiatric cause of the disturbance, and usually assures greater co-operation of the patient. In some functional disturbances relaxation of the hyperactive musculature may be sufficient treatment, or the rest obtained by means of drug therapy may actually contribute to healing of ulcerative lesions in a manner similar to the contribution of therapeutic pneumothorax in pulmonary tuberculosis or the mechanical splint in fracture cases.

One of the most widely used antispasmodics is atropine, either in its pure form as one of the salts of the alkaloid, as belladonna, or as one of the related natural alkaloids. Atropine itself is tropinyl tropate and may be represented by the structure in Figure 1.

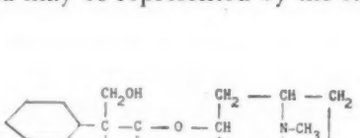
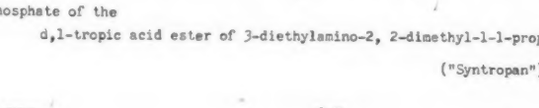


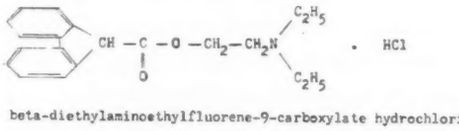
Fig. 1

Atropine has been one of the most dependable antispasmodics available, although it does suffer from certain well-known disadvantages which sometimes limit its usefulness. Therapeutic doses frequently dry the mouth, dilate the pupil, and paralyze the ciliary body to interfere with normal visual accommodation. Although these side actions are sometimes called "toxic," they really represent fundamental peripheral effects of atropine and are to be expected whenever sufficint amounts of the drug are given. True toxic effects of atropine are said to be due to the central actions of the drug, and might be expected in senstive patients with only moderate increases over the usual therapeutic dose. The margin of safety, therefore, with atropine is relatively small and represents the major limiting factor in use of this important compound.

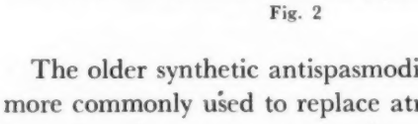
A number of synthetic compounds have been prepared which produce parasympatholytic actions similar to those of atropine and sometimes also direct inhibition of smooth muscle tone in a manner similar to the action of papaverine. From the chemical structures of typical examples of well-known synthetic "atropine-like" drugs indicated below, it will be seen that they resemble atropine in that they are esters of somewhat complicated but frequently different organic acids containing one or more rings. In the synthetic compounds shown in Figure 2, substituted amino ethyl groups replace the tropinyl radical of atropine.



phosphate of the
d,l-tropic acid ester of 3-diethylamino-2, 2-dimethyl-1-1-propanol
("Syntropan")



diphenylacetyldiethylaminoethanol hydrochloride ("Trasentine")

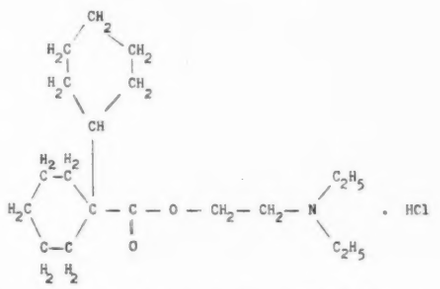


beta-diethylaminoethylfluorene-9-carboxylate hydrochloride ("Pavatrine")

Fig. 2

The older synthetic antispasmodics that are now more commonly used to replace atropine generally have the advantage over atropine of a wider margin of safety associated with some degree of specificity, so that when the therapeutic dose is given for treatment of spastic conditions, side effects on the mouth or eyes are uncommon. Compared with atropine, the limiting factor seems to be the variable therapeutic effect. While the synthetic compounds are usually safer than atropine, the response is not always as dependable, and for that reason they have only partly replaced the natural parasympatholytic alkaloids.

It was hoped that the test drug, diethylaminocarbethoxycyclohexyl hydrochloride* might possibly offer advantages in safety comparable to that of the older antispasmodics combined with efficacy similar to that of atropine. In structure it differs from the other esters of a substituted amino ethanol described above in that the rings in the acid are saturated. It may be represented by the structure shown in Figure 3.



diethylaminocarbethoxycyclohexyl hydrochloride ("Bentyl")

Fig. 3

Laboratory studies[1] indicate that Bentyl is approximately one-eighth as potent as atropine when assayed against that compound on the basis of the acetylcholine induced spasm in the isolated rabbit intestine. However, the mydriatic action of Bentyl was found to be only about 1/400 that of atropine and the inhibitory effect upon pilocarpine induced salivation was only about 1/300 that of atropine. Accordingly, a single dose of 10 mg. of Bentyl should be equivalent to several times an average human dose of atropine or belladonna containing 0.3 mg. of the alkaloid from the standpoint of antispasmodic potency, but would be only about 1/10 as potent in drying the mouth and even less potent in causing effects on the eye. Accordingly, preliminary observations were made in a series of patients who required antispasmodic therapy.

A series of forty-one patients were treated with Bentyl, given alone and in combination with barbiturates (phenobarbital, pentobarbital) and in combination with an antacid (magnesium trisilicate, hydrated aluminum hydroxide, and methylated cellulose). These patients were largely selected because of their failure to respond well to previous antispasmodic therapy with belladonna, atropine, Trasentine, Syntropan, or Pavatrine, with and without sedation such as barbiturates and bromides. They were adults ranging from twenty-one to fifty-nine years, and twenty-two were women, nineteen men. Bentyl was given orally in daily doses of 30 mg. usually divided into three single doses of 10 mg. each, before or after meals. A fourth dose of 10 mg. was occasionally given at the hour of sleep. Those patients who required concurrent sedation were given 10 mg. Bentyl tablets to which 15 mg. of phenobarbital or 15 mg. of pentobarbital had been added. Patients suffering from duodenal or gastric ulcer received medication six times daily, each tablet containing only 5 mg. of Bentyl in combination with magnesium trisilicate and hydrated aluminum hydroxide to antagonize gastric acidity and methylated cellulose which was included in the hope that it would serve as a protective covering for the ulcerated area and also possibly delay passage of the antacid from the stomach.

As will be seen from Tables I and II, the patients suffered from the irritable, spastic colon syn-

TABLE I

Condition Associated with Smooth Muscle Spasm	Frequency	Symptomatic Response: Virtually Complete Relief	Partial But Substantial Relief	Failure
Irritable, spastic colon syndrome	17	11*	4	2
Duodenal ulcer	8	7	1	0
Primary dysmenorrhea	10	8	2	0
Cholecystitis and biliary dyskinesia	5	5	0	0
Pylorospasm	4	2	1	1
Psychoneurosis	4	1	1	2
Food sensitivity	1	1	0	0
Diverticulosis	2	1	1	0
Gastric ulcer**	1	1	0	0
Mucous colitis	1	1	0	0
Totals	53	38	10	5

*Three cases responded only partially to Bentyl-phenobarbital, but complete relief was obtained when Bentyl-pentobarbital was substituted; one case required concurrent administration of Decapryn to obtain complete relief.

**Bentyl administered in combination with magnesium trisilicate, hydrated aluminum hydroxide, and methylated cellulose.

TABLE II

Symptoms	Frequency of Occurrence	Response: Virtually Complete Relief	Partial but Substantial Relief	Failure
Abdominal or epigastric pain or cramps	30	24*	4	2
"Gas"	12	9	3	0
Abdominal soreness and tenderness	10	9	1	0
Nausea	8	7	0	1
Abdominal distention	7	6	0	1
Diarrhea	5	5	0	0
Constipation	6	5	1	0
Eructation	2	2	0	0
Epigastric burning	2	1	1	0
Pyrosis	3	0	2	1
All symptoms**	85	68	12	5

*Three cases responded only partially to Bentyl-phenobarbital, but complete relief was obtained when Bentyl-pentobarbital was substituted; one case required concurrent administration of Decapryn to obtain complete relief.

**In a total of forty-one patients.

*Kindly furnished by the Clinical Research Division of the Wm. S. Merrell Company under the trade name "Bentyl Hydrochloride."

drome, duodenal ulcer, gastric ulcer, primary dysmenorrhea, cholecystitis, biliary dyskinesia, pylorospasm, psychoneurosis, food sensitivity, diverticulosis, and mucous colitis which produced a variety of symptoms such as abdominal or epigastric pain suitable psychotherapy. In one case of gastric retention associated with an organic lesion (duodenal ulcer) there was some temporary, partial relief of symptoms, but the patient required surgical care for permanent relief.

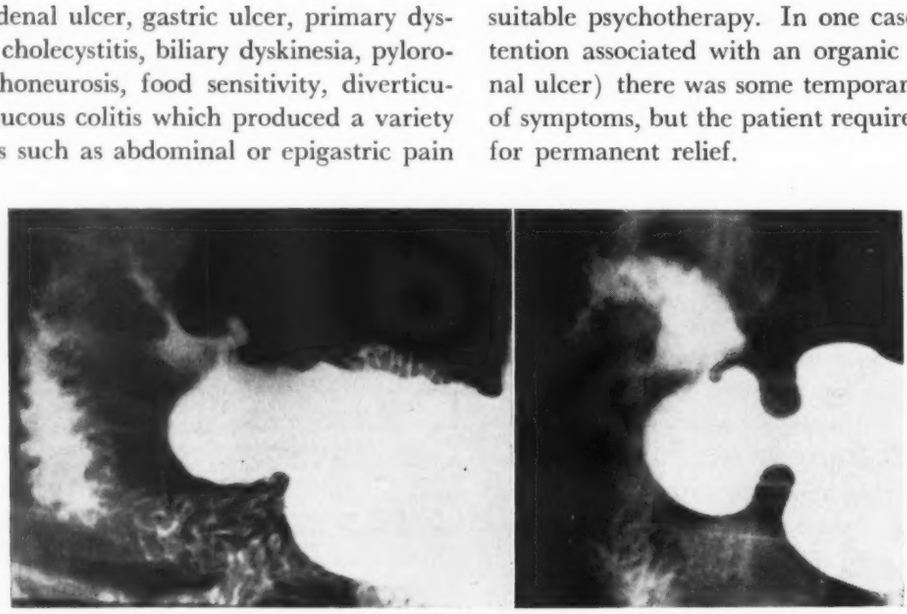


Fig. 4

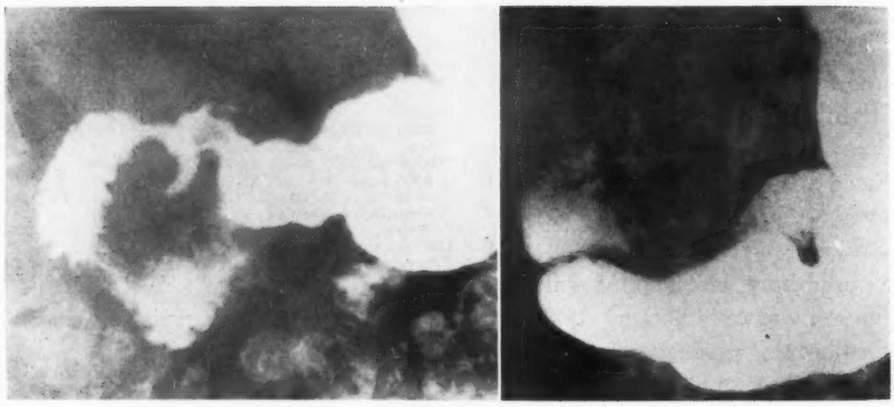


Fig. 5

Figures 4 and 5 illustrate two cases of peptic ulceration of the duodenum with considerable spasm and deformity, treated with ambulatory diets and Bentyl-antacid combination. Each tablet was made up to contain Bentyl hydrochloride (dimethylaminoethylcyclohexylcyclohexane carboxylate hydrochloride) 5 millograms with aluminum hydroxide 300 millograms and magnesium trisilicate 400 millograms. Eight tablets daily used in first two to four weeks of treatment, and thereafter six tablets daily in divided doses until evidence of healing.

Figure 4. (*Left*) Roentgenologic appearance of active duodenal ulcer in thirty-four-year-old man with clinical evidence of ulcer.

(*Right*) Roentgenologic appearance after twelve weeks of ambulatory treatment with diet and Bentyl-antacid combination. Marked clinical improvement.

Figure 5. (*Left*) Roentgenologic appearance of an active duodenal ulcer in a forty-eight-year-old man with history of recurring ulcer for seven years.

(*Right*) Roentgenogram taken 13 weeks after start of ambulatory treatment with diet and Bentyl-antacid combination.

or cramps, "gas," abdominal soreness and tenderness, nausea and vomiting, diarrhea and constipation, abdominal distention, eructation, epigastric burning, and pyrosis. As indicated in Tables I and II, the therapeutic response was surprisingly favorable, especially in the duodenal and gastric ulcer patients who received the Bentyl-antacid combination and patients suffering from dysmenorrhea. Poorest results were obtained in the patients who were frankly psychoneurotic, and were ultimately referred to psychiatric consultants for

Strangely enough, three of the patients who received only partial relief from the Bentyl-phenobarbital combination were rendered entirely free from symptoms when switched to Bentyl-pentobarbital, and one other did not obtain complete symptomatic relief until Decapryn (which has a mild atropine-like effect as well as a potent antihistaminic action) was added to the regimen. Perhaps these observations were the result simply of continued treatment, since the patients all received the usual dietary, supportive, and psychological

guidance and therapy, none of which can be replaced by any antispasmodic drug.

Side effects were virtually absent in this small series of forty-one patients. One patient suspected that she might be slightly dizzy from the drug, while two suspected nausea as a side effect. In one of these cases the nausea was probably a symptom of the duodenal ulcer that was present, and in the other it was definitely related to the bitter taste of the tablet and was no longer present when similar doses of the Bentyl-antacid were substituted. Perhaps capsules would be a more suitable pharmaceutical form than tablets for this compound.

Patients received treatment with Bentyl hydrochloride ranging from one week to three months, and in seventeen cases where the drug was administered long enough to justify blood counts, blood chemistry, liver function tests, and urine studies, no abnormalities were detected.

Fundamentally, effective antispasmodic drugs are of value largely in relieving symptoms, making the patient more comfortable, and perhaps in making the patient more co-operative while fundamental diagnostic and therapeutic procedures, some of which require time, are employed. The x-ray pictures in Figure 4 and Figure 5 indicate the healing of duodenal ulcers in two of the patients who experienced virtually complete relief from the ulcer pain while on the Bentyl-antacid compound. Further studies may perhaps show that the beneficial effects of antispasmodic therapy may be similar to those of other therapeutic procedures which set at rest the diseased or injured organ or structure.

Frequently the reduction in abdominal tenderness and occasionally even some rigidity associated with a decrease or cessation of subjective complaints offered a considerable degree of objective confirmation of the efficacy of therapy. This was particularly noteworthy in several of the gallbladder cases. Regularity of the stool habit in patients previously suffering from alternating diarrhea and constipation similarly confirmed the subjective response. General manifestations of improved appetite, strength, vigor, and sense of well-being were associated with the subjective improvement.

Conclusion

Bentyl hydrochloride, a new antispasmodic drug, has been studied in a small series of patients selected largely on the basis of failure to respond to atropine and the older synthetic substitutes. It has been well tolerated and generally effective, especially when given to duodenal or gastric ulcer patients in combination with an antacid. It does not replace surgery, diet, or psychotherapy when they are indicated.

Reference

1. Brown, B. B., et al: J. Am. Pharm. A., Sc. Ed. (in press).

MSMS

PSYCHIATRY AND THE DRIVER

(Continued from Page 1296)

(reports from the hospital, applications for driver's license, et cetera) that the individual has been in a mental institution, before his license is issued, he should be examined by a physician, preferably a neuropsychiatrist.

6. This examination, also including a probationary period, is especially indicated in cases of organic brain disease—cerebral arteriosclerosis, other senile conditions, neurological incapacitating conditions, schizophrenia, alcoholism, convulsive disorders, drug addiction, physical handicaps, feeblemindedness, manic depressives, any obsessive-compulsive states, and conditions as revealed. Some of the so-termed psychopaths, as the egocentric, are hazards.

7. All patients of state institutions should be fingerprinted.

8. All applicants for driver's license should be fingerprinted.

9. All fingerprints (7 and 8) should be searched in the Federal and State Bureaus and centrally located.

10. In cases in which it has been recommended by the psychiatrist that the driver's license be held up, these should not be released without approval and further observation and examination by psychiatrists. All hospital officials releasing committed patients should issue a letter approving or disapproving the patient being allowed to drive. A driving test may not determine the potentiality. Similarly in uncommitted cases, the examining private psychiatrist, as now is compulsive in California, should issue reports of patients treated for psychosis and should submit a letter rendering the patient unsafe as a driver.

11. Many studies have revealed that it is possible to make psychiatric predictions or prognoses, not only upon the Modus Operandi or analysis of the crime, accident, or commitment, but upon the consideration of other personality factors.

Incapacity

Case Report

By Joseph M. Erman, M.D.

Detroit, Michigan

ON December 29, 1940, at 2:55 p.m., Ben J. entered Receiving Hospital in coma. The next day at 4:35 p.m. he was dead. Ben was seventy-seven years old. He was well known to the North End Clinic, carrying a fantastic 300-plus hypertension at times.

Some history appears on the Receiving Hospital chart. Ben was getting about in the month of December, 1940. But he complained of headache and also of numbness and slight weakness of the right side. Paralysis was not apparent. On December 29 Ben got up and saw animals. He was put to bed and fell asleep. Later he could not be aroused in one hour's trying and was brought to the hospital.

Examination recorded at Receiving Hospital: Well-developed, undernourished. Skin: warm, dry. Tissue turgor lost. Pupils pinpoint although no morphia has been given. Blood pressure, right 210/110, left 230/90. Kussmaul and Cheyne-Stokes respirations. Auricular fibrillation. Apical impulse forceful. Bilateral ankle clonus, more marked on right. Babinski on right. Reflexes changing during examination. Right facial weakness and weakness right arm and leg. Liver enlarged one fingerbreadth. Pulse 94 to 148. Respirations 38 to 60; last 50. Temperature 100° to 104.6°; last 103.8°. Albumin one plus, urea 64 mg., Kline negative.

Treatment: Oxygen; digalen; 5 per cent glucose; sulphathiazole by stomach tube and sulphapyridine.

Impression: Cerebrovascular accident. Right hemiplegia. Hypertensive cardiovascular disease. Left ventricular hypertrophy. Auricular fibrillation. Bilateral broncho-pneumonia (hypostasis).

Five months previously Ben was in St. Mary's Hospital for right weakness and aphasia, staying three months, moving over to Burns Home for one month and home for the last month of his life.

The earliest record of the North End Clinic chart is dated August 31, 1931. Dr. Saul Rosenzweig elicited in the history that nine years previously Ben had been turned down for insurance on account of blood pressure over 200. Dr. Rosenzweig's impression: "Chronic degenerative heart disease, Class II, with hypertension and auricular fibrillation. Blood pressure 220/110."

On June 4, 1936, a blood pressure was recorded as 300/120!!! There was no deficit and no edema. All the time from 1931 to 1936 Ben had been taking digitalis faithfully. On February 23, 1937, his blood pressure was 300. On April 28, 1937, Ben presented himself with a complaint of a severe headache. He was warned, "Go to bed" because of the danger of cerebral hemorrhage. But for almost four years more this was forestalled.

X-rays in 1935 and in 1940 showed a pathological heart. Albumin was a trace to one plus but was negative at times. On two occasions one plus sugar appeared: January 5, 1937, and October, 1940. Fundoscopic was compatible with his age.

From August 5 to 28, 1937, Ben was a patient in Grace Hospital for hypertension, arthritis of lumbar spine, hypertensive heart disease and neuralgia.

A right inguinal hernia and later bilateral were treated with a truss. Vascular dermatitis venenata both forearms was treated over a period of the last seven years. Prostatitis was treated.

A note on July 11, 1939, showed that at age seventy-six years he was commissar and cook for two sick, grown daughters and three sons with whom he made his home.

Known hypertensive from age fifty to seventy-seven, Ben was probably hypertensive long prior to 1922. Known fibrillating nine years, he carried on an activity which might be viewed as amazing for his age. A curious speculation may be suggested to the psychiatrist as to why Ben's grown daughters were sick while he did the house cooking and shopping from age sixty-eight to seventy-seven while afflicted with hypertension, fibrillation and impending cerebral bleeding and paralysis.

MSMS

It seems not unfit that the scholar should deal plainly with society and tell them that he saw well enough before he spoke the consequence of his speaking; that up there in his silent study, by his dim lamp, he fore-heard this Babel of outcries. The nature of man he knew, the insanity that comes of inaction and tradition, and knew well that when their dream and routine were disturbed, like bats and owls and nocturnal beasts they would howl and shriek and fly at the torch-bearer. But he saw plainly that under this their distressing disguise of bird form and beast form, the divine features of man were hidden, and he felt that he would dare to be so much their friend as to do them this violence to drag them to the day and to the healthy air and water of God, that the unclean spirits that had possessed them might be exercised and depart. The taunts and cries of hatred and anger, the very epithets you bestow on me, are so familiar long ago in my reading that they sound to me ridiculously old and stale. The same thing has happened so many times over (that is, with the appearance of every original observer) that, if people were not very ignorant of literary history, they would be stuck with the exact coincidence, I, whilst I see this, that you must have been shocked and must cry out at what I have said, I see too that we cannot easily be reconciled, for I have a great deal more to say that will shock you out of all patience.

Every day I am stuck with new particulars of the antagonism between your habits of thought and action, and the divine law of your being, and as fast as these become clear to me you may depend on my proclaiming them.

—Ralph Waldo Emerson,
Contributed by Mental Hygiene Commission

President's Message

Freedom or Serfdom

Will the people be servants of the state which owns all and directs all, or will the people direct the state?

What is a trillion dollars? I don't know what it means but our national debt is over one quarter of it. If 100,000,000 of our citizens made fifty dollars a week and turned over their entire income for one year, we could pay off that debt if the government would stop deficit spending. The interest alone on this amounts to five times as much as it cost to run the government in 1915. If this debt increases year after year, how long before the load will become unbearable? What happens to insurance, annuities, wages, pensions, securities, etc., when a default comes on government obligations? At that time the citizens of this country will realize *we* are the government. It is *our* loss.

What influence will the Korean war have on our financial and national security? I believe with Major Alexander P. de Seversky that this is but the first of many such incidents to come. It would appear that Formosa is next. I believe that we are taking the shortest cut to insolvency and will gain a position wholly untenable. It is my belief further (with de Seversky) that with our superior manufacturing abilities and know-how, we could control the air from our own shores and be the deciding factor for world freedom and peace, without being financially submerged.

In reviewing the seriousness of the problems confronting us today we look to Washington for reassurance. We find instead that the socialists have nearly completed the welfare state. We are told many departments are infiltrated with Communists, fellow travelers and spies.

At the moment we are losing this crucial battle on Americanism, round by round. Good American citizens are not creating a competent state of awareness right at home.

The American people when fully aroused of dangers confronting them have always responded in the past.

Men and women of medicine must continue to combat every menace to our national safety. Will the people be servants of the state which owns all and directs all, or will the people be and direct the state?

C E Umphrey M D

President, Michigan State Medical Society

Editorial

COMPULSORY FEDERAL CONTROL OF MEDICINE

NOT A CHANCE has been missed by the Administration to extend its program leading to the complete socialization of the medical services of the entire nation. In our September editorials we outlined the proceedings promulgated by which medical services to the populace, in case of catastrophy, would be implemented by Oscar R. Ewing and the U. S. Public Health Service.

We quoted a letter to the Governor from the Director, Civilian Mobilization Office: "We will be relying upon the Public Health Service for medical guidance for the states under our long-range civil defense planning."

The health services which will be necessary in case of extensive atomic or other attack causing catastrophic damages will require many times the personnel of the Public Health Services, or the State and local health offices. The health services which are to be rendered will be the private doctors who escape the holocast which we are presupposing will strike great areas of our country. Bearing this in mind, now read this excerpt from Chapter 16, "Health Services," N.S.R.B., Document 128, entitled "United States Civil Defense," Executive Office of the President, N.S.R.B.:

"In view of technical and professional requirements, the civil defense health and medical measures and services must continue to remain a responsibility of existing health agencies and individuals. These agencies and individuals will perform their wartime functions under civil defense rules and regulations.

"Close liaison between civil defense organization and peacetime health services is therefore imperative. Existing health agencies should, in wartime, be responsible for civil defense health requirements so that a creation of new duplication agencies will be avoided.

"This principle has been followed in the planning of Federal civil defense health services. The United States Public Health Service has agreed to provide medical and other officers to staff Federal civil defense central and regional offices.

"Initially this function may be carried out through the health personnel assigned to existing Federal Security Agency regional offices. Later the function will be moved to wherever the Federal regional civil-defense offices are established.

"In each state, the state health officer should be placed in charge of all state civil defense health and medical services; and cities should appoint local health officers in the same manner."

In addition to the attempts above referred to for gaining administrative control of medical services, the government, again through Oscar Ewing's department, has assumed another large slice of medical practice. (Will they have to build some more hospitals at fifty thousand dollars per bed?) The following communication was released on October 4, 1950:

"Veterans of the Spanish-American war, Boxer Rebellion and Philippine Insurrection are now eligible for outpatient medical care *without regard to service-connection*, the Veterans Administration announced today.

"Regulations implementing their right to such care, based on Public Law 791, 81st Congress, have been wired to all V-A Regional Offices.

"To be eligible, a veteran must have served some time between April 21, 1898, and July 4, 1902 (or July 15, 1903, if the service was in Moro Province, Philippine Islands), and was discharged other than dishonorably.

"An estimated 118,000 veterans have become potentially eligible for full medical and dental care in V-A clinics, or at home by fee basis physicians and dentists for any illness or disability."

There can be only one interpretation of that document; another 118,000 veterans, (and their families will follow) are placed upon the socialized medicine rolls for complete care, home, office, hospital, service connected or not.

Gradually Mr. Ewing and the Administration are attempting to take over the complete practice of medicine, one bite after another, without protest, and soon there will be nothing left worth fighting for.

In September we questioned if we were not already too late, but we pleaded for medically administered programs to supervise and distribute medical services. We expect people will be cared for, and whatever can will be done to alleviate and mitigate human suffering, but again Oscar Ewing has taken over some more directive powers. If an emergency arises he will be the central figure to whom all must look, even the doctors who think they are private practitioners.

CONTROL BY INTIMIDATION

IT IS NOW about two years since the splurge of administration inspired F.B.I. investigations of many of the state, county, and other medical organizations, including Michigan, Michigan Medical Service, and the A.M.A. itself. In Chicago, at the A.M.A. headquarters the F.B.I. men occupied the Board Room for months, and perused every piece of paper they could find in that mammoth office building.

In Oregon the Justice Department instituted suit against the Oregon State Medical Society, eight county medical societies, and certain officers. On September 28, 1950, Federal Judge Claude McColloch ruled that Oregon's organized medicine has not violated the Sherman anti-trust act in its prepaid service.

The government charged that the state medical society, a number of county societies, and several physicians sought to monopolize the field of prepaid medical care by refusing to deal with private agencies and by disciplining physicians who did deal with them.

"I hold that the Oregon physicians service is not a conspiracy, but rather an entirely legal and legitimate effort by the profession to meet the demands of the times for broadened medical and hospital service, eliminating the evils of privately owned concerns as well as the element of private profit," Judge McColloch wrote.

Recently the F.B.I. has been investigating the Illinois State Medical Society, having demanded and been granted access to all the records in Monmouth, the home of Harold M. Camp, secretary for twenty-six years. In reporting this investigation the *Chicago Tribune* said:

"Dr. Harry M. Hedge, president of the Illinois State Medical Society, denounced 'that man in the White House' for assigning the F.B.I. to investigate the society 'to help Senator Lucas' in the latter's campaign for re-election.

" 'It is nothing but a political move and even the F.B.I. doesn't like it,' Dr. Hedge asserted, adding that the society had three courses of action open to it.

" 'The first of these courses,' said Dr. Hedge, 'was to tell them "No!"—short of going to hell; the second was "Help yourself," and the third, which we have decided to adopt, is that we have nothing to hide.

" 'Having decided on the third course, we intend informing the F.B.I. agents that they can see anything they wish provided they make a request beforehand through our attorney for specific information. We don't want to buck them completely. We have done nothing wrong.' "

Later, the Illinois State Medical Society issued a statement to the press in which it said that the Council, governing body of the society:

"Is quite certain that the society has violated no law and the Council members are aware that the F.B.I. enjoys a well-deserved reputation for conducting investigations fairly and objectively.

"The Council looks with extreme displeasure upon the apparent motivation of the Department of Justice in ordering the investigation. Within the last two or three years, more than twenty-five state and county medical societies have been similarly investigated, apparently without results.

"This suggests very strongly to many physicians that such investigations are instigated primarily to punish or intimidate doctors and their professional organizations for their strong and determined opposition to the national administration's compulsory sickness insurance program.

"Under the circumstances many of the society's 10,000 members will doubtless find it difficult to avoid the conclusion that the investigation ordered by the Justice Department is a reprisal against them for their interest and individual activity in national political and legislative affairs."

We hope the Illinois activity is not a reprisal, but such proceedings have far-reaching effects, and could play right into the hands of the other power-mad bureaucrats who are always gaining more authority and control.

WHY CANCER PATIENTS DELAY SEEKING DIAGNOSIS AND TREATMENT

(Continued from Page 1270)

This discussion has dealt with the delays in cancer diagnosis which are the responsibility of the patient. Physicians also have a heavy responsibility in this matter. Refusal or neglect to make a careful examination of the patient often dooms that patient to critical dangers later on. The "I-didn't-think-of-cancer" excuse is no longer tenable, especially in view of the intensive professional education campaign that has been waged in Michigan during the past four years and is still continuing. *Cancer must be suspected and ruled out in every diagnosis by every physician.* Not until then will the physician have discharged his full responsibility to the community he serves. He also must take leadership in the education of his patients by teaching them the value of periodic examinations to detect cancer in early stages and the dangers in delay when suspicious symptoms are present.

EWING MUST GO!

Note: The following statement was released to the press associations from Chicago, Friday, September 29.

Chicago, September 29.—The American Medical Association, in a blistering indictment of Federal Security Administrator Oscar Ewing, which stated that he had twice been given a vote of "no confidence" in Congress, today characterized him as "a disappointed, embittered bureaucrat, who should be removed from office before he does further harm to the country."

Dr. George F. Lull, general manager of the AMA, who issued the statement, declared:

"Mr. Ewing, in his speech yesterday before the American Jewish Congress, descended to the depths of political demagoguery when he falsely implied that the American Medical Association was practicing discrimination against Jews.

"He has long been a fomenter of class hatreds and he is now attempting to incite religious and racial hatreds in the manner of Hitler's Germany.

"Mr. Ewing is a case of arrested political development and his irrational statements undoubtedly are a consequence of thwarted ambitions and a growing persecution complex, but he is wholly unfit for public office.

"The two Houses of Congress, in successive years, have given Mr. Ewing a decisive vote of 'no confidence,' by rejecting his attempts to gain Cabinet stature and control over the medical profession through the creation of a Department of Health, Education and Security.

"President Truman should finish the job and dismiss Mr. Ewing from the public service before he does further harm to the country."

AMERICAN MEDICAL ASSOCIATION ACCUSES JOHN D. DINGELL

Chicago, October 6.—A charge of misuse of the Congressional Record for unethical purposes was leveled today at Representative John D. Dingell, of Michigan, by the American Medical Association.

In an open memorandum sent to every member of Congress, Dr. Elmer L. Henderson, president of the AMA, called attention to a widely distributed reprint of Dingell's speech attacking the Association's nationwide advertising campaign as a "Twenty Million Dollar Smear Campaign," and asked the Congressmen if Dingell's "willingness to damage a medium of great public usefulness and dependability," was in their opinion, an ethical and proper use of the Congressional Record.

"I am well aware," said Dr. Henderson's memorandum, "that the Congressional Record did not carry the headline Congressman Dingell attributes to it. However, as Mr. Dingell is equally well aware, most Americans who see his ugly document, will not have the same knowledge."

The Dingell release is headed by the great seal of the United States and the imprint of the Congressional Record. Beneath these, in bold type appears a headline, "Help Fight Medical Lobby $20,000,000 Smear Campaign," followed by Dingell's speech as it was printed in the appendix of the Record.

Dingell's figure of $20,000,000 was called by Dr. Henderson "a fraudulent figure released by Mr. Oscar Ewing's office," the Federal Security Agency. Actually, the AMA president said, the Association is spending $1,110,000 on advertising in newspapers, magazines and radio. It is hoped, he said that "people who believe in the principle that 'The Voluntary Way is the American Way' will double the space the doctors have paid for."

"We have felt," the memorandum said, "that placing medicine's story as the doctors see it, in the public press, at the doctors' own expense, is in the finest American tradition," and asked Congressmen if they agreed with Dingell's charge that such use of advertising is an "insidious tactic to corrupt the public mind, or a proper exercise of free speech."

Pointing out that he himself is a life-long Democrat and that there "are probably more Democrats than Republicans among the officers and leaders of the American Medical Association," Dr. Henderson expressed surprise that Representative Dingell and other Democratic Party workers consider the matter of health insurance a partisan one.

"American medicine considers compulsory health insurance a matter of public health and welfare—not a matter of party politics. We have not sought party endorsement of any kind," he said.

Growth Through Co-operation

The Story of the Michigan Health Council

Depicted on the cover of this issue of THE JOURNAL is the expanding statewide program of the Michigan Health Council. Representing the important factor of co-operation in the illustration are the doctor of medicine, the businessman, the housewife, the farmer, the school teacher, the hospital administrator, all joining hands with other representatives of the local people in a community health council.

In eighteen months, a successful effort has been made to ascertain the health facilities of rural areas and industrial establishments, to define a common ground for community health effort, and to develop a clearing house for health information for all the people. The vehicle for these accomplishments has been the Michigan Health Council, an organization that for the first time has made twenty-one major health organizations realize that there is common advantage to be gained by working together.

The key to the present success has been the planning of a program before people *in their own communities*. Prospects look bright for the future as ideas spark in community after community to solve health problems by sheer impact of team play.

The Michigan Health Council itself is evidence of the possibilities for GROWTH THROUGH CO-OPERATION. It was originally organized in 1942 as a non-profit Michigan corporation for the purpose of providing promotional services to its members. The members were the Michigan State Medical Society, Michigan Hospital Association, Michigan Hospital Service, and Michigan Medical Service.

GROWTH THROUGH CO-OPERATION

- **Expansion of Voting Membership—from 4 to 24 members.**
- **Expansion of Associate Membership—from 0 to 27 Community Health Councils.**
- **Michigan Rural Health Conference Co-Sponsorship expanded from 41 to 68 organizations in 1950.**
- **Michigan Health Council Bulletin—expanded from 0 to 1,150 circulation.**
- **Projects—constant expansion of program of projects:**
  - **—Michigan Health Council—clearing house on health questions.**
  - **—Film Booking Information Service.**
  - **—Establishment of Reference Library.**
  - **—Compilation and publication of Michigan Health Council Directory of Health Organizations.**
  - **—Collaboration on Michigan Health Council—Brookings Institute Study on Availability of Medical Service in U.S.**
  - **—Civilian Defense Program—participation in the dissemination of information.**
  - **—Inauguration of Health Information Centers network in Michigan.**
  - **—Inquiries from 22 states for information on Michigan Health Council structure and program.**
  - **—Participation in 19 important state and national health conferences and activities.**
  - **—Awards for worthy community health accomplishments.**
  - **—Film production on Community Health Council organization procedure.**

With the impetus born of a new idea plus aggressive promotion, the Michigan Health Council when first organized carried on a program of information from the public platform on medical-socio economics and aided in such projects as nurse recruitment drives. But the organization ground to a slow walk because it had no local outlets and because its basic membership was limited. It just wasn't a common meeting ground for *all* health organizations in Michigan — it wasn't *the* Michigan Health Council. So in November, 1949, a halt was called to "catch a breath" and re-evaluate where the organization was going—where it could go and what should be done to make it "click."

A New Philosophy and New Activity

True Health Statesmanship entered the picture when The Council of the Michigan State Medical Society bought an idea. They decided to support financially a new concept of the Michigan Health Council. The new concept was, that the organization become a haven for the health projects of all

Groups such as the above, meeting together to study and plan for local health needs, define the word "Council" as "Common Meeting Ground."

Michigan organizations having a genuine major interest in health and that it provide a mechanism for planning a construction program before people in their own home town.

The Michigan State Medical Society realized that control by financial strength acted as a barrier to participation by organizations with assets other than those of a financial nature. Consequently, a series of meetings of major health groups brought forward changes in the By-Laws of the Michigan Health Council so that if any group were to dominate in the organization it would be by sheer interest or participation. The Michigan State Medical Society backed its decision with an outright grant of $7,500. Its leadership was closely followed by Michigan Medical Service and by Michigan Hospital Service with grants of $7,500 each.

Launched upon its new career the Michigan Health Council on February 19, 1950, established offices in Lansing under the direction of the newly employed Executive Secretary, Eugene Wiard.

J. Hirschman, M.D., Detroit (*extreme right*) and J. R. Rodger, M.D., Bellair (*third from right*) conducting a Rural Health Conference discussion panel.

"Established offices" is a nice organizational phrase. Actually Mr. Wiard found himself without a chair or a desk! However, the new Executive Secretary proceeded to renovate, repaper and repaint the office space and at the same time set out to beg, borrow and st— acquire the necessary equipment to get going. Thanks to the co-operation of Michigan Medical Service—Michigan Hospital Service and Michigan State Medical Society who "advanced" enough equipment, supplies and working materials to get started, the Michigan Health Council was functioning in no time and going about the business of its major objective of encouraging the development of community health councils, its No. 1 project.

A. S. Brunk, M.D.
First President

Community Health Councils Stimulated

One of the early Community Health Councils organized illustrated the value of the community organization working together for a common cause. A two-county area with a jointly sponsored county public health department found itself suddenly facing a serious situation when the commissioners of one county voted to discontinue their appropriation.

A community health council was brought into being quickly with broad representation from many health organizations in the area and from the people at large. It met regularly to chart a course designed to encourage the supervisors to rescind their decision and provide the needed appropriation. This concerted action was successful in demonstrating the people's interest in continuation of the department. Soon the supervisors reversed their decision and appropriated funds and a health department again services people of this area.

Twenty-seven community groups now hold associate membership in the Michigan Health Council and organizational activities are going on in five other counties at this time (Midland, Montcalm, Kalkaska, Crawford and Clinton counties). Preliminary organizational plans are developing in three other Michigan counties simultaneously.

Michigan Rural Health Conference

While this is held to be its first and most important project, a number of other important activities have been developed and accomplished. Under the aegis of the Michigan Health Council the annual Michigan Rural Health Conference has grown, in a period of four years, from the idea stage to a positon of recognition as one of the important health meetings on Michigan's Fall Calendar. The Rural Health Conference originally was sponsored financially by the Michigan State Medical Society. Through the able leadership of such members as J. S. DeTar, M.D., E. I. Carr, M.D., H. B. Zemmer, M.D., C. E. Umphrey, M.D., J. R. Rodger, M.D., and others, the Conference has experienced a constantly expanding history as evidenced by the growing list of Co-Sponsoring organizations which has been increased from 30 groups in 1947 to 68 Michigan organizations in 1950.

J. S. DeTar, M.D.
President, 1950

For the past two years this conference has been sponsored financially by the Michigan Foundation for Medical and Health Education, Inc., which has extended a hand of co-operation and an offer of co-sponsorship to any worthy Michigan health group. Attendance at the two meetings has grown from several hundred in 1947 to more than 500 in 1950.

Directory of Health Organizations

The Michigan Health Council Directory of Health Organizations in Michigan, developed by the Michigan Health Council, fills a long-standing need in Michigan for such a reference volume. The Directory lists alphabetically more than 90 important health organizations operating in Michigan giving the routine directory information as to location, headquarters, officers etc. plus a review of each organization's state and local level program.

Functioning as a medium for the dissemination of information, the Michigan Health Council through its monthly Bulletin (circulation 1,150), its Community Health Councils, and its participation in conferences and meetings has become an important medium of contact between the Michigan State Medical Society and other state level

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Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

Approximately 1,000 Michigan public health workers will meet in the Pantlind Hotel and Civic Auditorium, Grand Rapids, November 29 to December 1, in the thirtieth annual Michigan Public Health Conference which will consider new weapons against disease and the role of public health people in disaster and in civil defense.

At the opening session on Wednesday afternoon, Haven Emerson, M.D., American Public Health Association Consultant; Franklin H. Top, M.D., of the University of Minnesota; Jerome Conn, M.D., of the University of Michigan; Albert E. Heustis, M.D., State Health Commissioner, and F. S. Leeder, M.D., Director of the Division of Disease Control, Records and Statistics, will discuss new disease fighting drugs and diagnostic procedures.

The Thursday program is devoted entirely to section meetings in which public health directors, public health dentists and dental hygienists, public health nurses, engineers and sanitarians, nutritionists, venereal disease personnel and clerks will discuss mutual problems and responsibilities.

How to meet health problems in time of disaster will be considered at the Friday morning general session.

Members of the medical profession will be welcome at any or all sessions of the conference.

To conserve the hearing of Michigan school children and to help those handicapped by hearing loss, the Michigan Department of Health, for the eighth consecutive year is providing hearing consultation service to Michigan communities. Requests for the service have been received from school or community groups in thirty counties in the state so far this year. Requests are routed through the local health departments.

In the hearing conservation programs, group hearing tests are given by local people trained by Michigan Department of Health hearing consultants. When the initial test indicates an abnormal hearing condition, the Department consultants follow up with individual tests to determine the amount of hearing loss. Local health departments, school people and community groups then arrange for parents to take the child to ear specialists for examination and proper care.

More than 450,000 Michigan children have been given group audiometer tests since the Michigan Hearing Conservation Program began in January, 1943. Of these, three per cent showed some hearing loss. Of the children who received medical treatment, more than 77 per cent improved, 50 per cent of them to normal hearing.

Robert June, M.D., has joined the staff of the Division of Laboratories, Michigan Department of Health, as co-ordinating physician. Dr. June is a graduate of the Loyola University School of Medicine, Chicago.

John Lynch, M.D., industrial health physician with the Division of Industrial Health, resigned effective September 29 to take a position in industry.

John Mancini, D.D.S., has joined the staff of the Section of Dentistry to be in charge of the Sturgis Dental Clinic.

Maternal and Child Health program administrators from thirteen midwest states observed the hearing conservation trailer at a Children's Bureau conference in Chicago early in October. This was made for the Michigan Department of Health under the supervision of its hearing consultants.

A total of 155,585 fair patrons visited the Michigan Department of Health's tent show "Since Adam and Eve" which presented venereal disease facts on the midways of eight county and state fairs during the summer and early fall.

A supplement to the 1950 catalog of the Michigan Department of Health Film Loan Library has been prepared and can be obtained from the Department. The Film Loan Library now has 242 different motion picture films, film strips and seven sets of slides, all on health subjects, which can be borrowed for showing in local groups.

Last year 469,407 school children and adults in seventy-eight counties of the state attended 10,471 showings of films and slides from the Library.

Beginning in January, 1951, the Division of Tuberculosis and Venereal Disease Control will schedule the visits of mobile chest x-ray units to the local communities of the state a year in advance. Request for a mobile chest x-ray unit to visit a community is made through the local health department. This scheduling a year in advance does not include the county fair surveys.

Detailed plans and specifications for a new laboratory building for the Western Michigan Branch laboratory of the Michigan Department of Health in Grand Rapids are now being prepared by the Department. Funds for the much-needed building will be requested from the state legislature. The Western Michigan Branch laboratory provides diagnostic and analytic services for physicians and hospitals in twenty-nine western counties of the state.

Col. Edward D. Rich, who became Michigan's first State Sanitary Engineer in 1911 and served as Director of the Division of Engineering of the Michigan Department of Health for thirty-five years, died in his Lansing home September 29.

An outstanding authority in his field, Colonel Rich pioneered in water sanitation, sewage treatment, chlorination and resort sanitation in the state and in the nation.

Communications

Wilfrid Haughey, M.D., Editor,
610 Post Building
Battle Creek, Michigan

Dear Doctor:

The editorial on "Trauma and Cancer" in the August issue of THE JOURNAL is a sane and common sense approach to a controversial subject. We feel that our Legal Department should have an opportunity to read it.

Hence, we are asking if you have a reprint that one might obtain to pass on to those who handle these cases in the courts.

Very truly yours,

R. G. COLYER, M.D.
Medical Department,
Fisher Body Division,
General Motors Corp.
Detroit.

September 25, 1950

* * *

U. S. TREASURY DEPARTMENT
Office of Commissioner of Internal Revenue
Washington 25, D. C.

Michigan State Medical Society
2020 Olds Tower
Lansing 8, Michigan

Gentlemen:

Reference is made to the information submitted by you for use in determining the status of the Grand Rapids Rheumatic Fever Control Center for Federal income tax purposes.

The records of this office disclose that in Bureau ruling dated June 7, 1939, you were held to be entitled to exemption from Federal income tax under the provisions of section 101 (7) of the Internal Revenue Code and corresponding provisions of prior revenue acts. This ruling was affirmed May 22, 1944.

The information submitted discloses that a standing committee for the Rheumatic Fever Control program is selected annually by the President of your organization. The purposes of the program are finding cases, diagnosing them, and the training and education necessary to bring the disease under control in Michigan. This work is carried on through the Rheumatic Fever Control Centers (fifteen in Detroit and twelve in other parts of the State) the chairmen of the Centers are nominated by the county medical society in whose jurisdiction the Center is located and are appointed by your organization. These Centers are financed through contributions from various organizations and registration fees paid by individuals using the services of the Center. Since these Centers are

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U. S. TREASURY DEPARTMENT

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an activity maintained and operated by you a separate ruling is not necessary with respect to their status.

Based on the foregoing it is held that **contributions made to you to be used exclusively for the operation of the various Centers are deductible by the donors in computing their taxable net income in the manner and to the extent provided by section 23 (o) and (q) of the Internal Revenue Code, as amended.***

Bureau letter dated July 27, 1950, addressed to the Grand Rapids Rheumatic Fever Control Center, in which it was advised to file income tax returns since it had failed to establish that it was entitled to an exempt status, is hereby revoked.

By direction of the Commissioner.

Very truly yours,

E. I. McLarney,
Deputy Commissioner

*Lines set in boldface type by editor's direction.

* * *

October 5, 1950

Dr. L. Fernald Foster, Secretary
Michigan State Medical Society
Lansing 8, Michigan

Dear Dr. Foster:

I wish to express my deep appreciation of the Council's approval of our program for the State of Michigan.

I know of no one in our program who has been more vital in developing this program than Dr. Zemmer, himself. I am glad that he stressed that no treatment would be involved in these clinics.

It is the policy of our Board, based upon evidence from physicians and patients, to attempt in every possible way to cement and improve the relationship between the Epileptic and his private local physician. The Board believes that treatment in this illness can only be adequately carried out by the medical man who knows his patient well and who carries a constant attendance.

We have had continual experience that indicates to us that a part of the illness of convulsions is that the patient wanders from doctor to doctor never giving one man adequate chance to try his skills. We feel it is vital in adequate planning for the Epileptic to prevent further occurance of this behavior which probably is also a symptom of the total condition.

It is our prime desire that we spread what little is known scientifically and medically about this illness to the medical men who have to handle the problems.

I hope you will allow us to call upon you again for help in carrying out our plan.

Sincerely,

A. J. DerByshire, Ph.D.
EEG Department
Michigan Epilepsy Center

96 West Ferry Avenue
Detroit 2, Michigan

. . . . . NEWS MEDICAL

MICHIGAN AUTHORS

Walter G. Kin, M.D., Ann Arbor, Mich., published an article, "Treatment of Far Advanced Carcinoma of the Breast: Present Status of Testosterone Therapy," in the A.M.A. *Archives of Surgery,* October 1950.

John Reid Brown, M. D.; Solomon G. Meyers, M.D.; Joseph L. Posch, M.D; and Owen Deneen, M.D., of Detroit, Mich., published an article, "Massive Hemorrhage from the Upper Gastrointestinal Tract: A Study of Three Hundred and Twenty-Four Cases Observed at the Detroit Receiving Hospital Over a Nine-Year Period," in the A.M.A. *Archives of Surgery,* October, 1950.

F. Bruce Fralick, M.D., of Ann Arbor, Mich., published an article, "The Orbit: Review of the Literature," in the *Archives of Ophthalmology,* September, 1950.

Henry T. Johnson, M.D., Lansing, Mich.; **Jerome Conn, M.D., Vivian Iob, Ph.D.,** and **Frederick A. Coller, M.D.,** of Ann Arbor, Mich., published an article, "Post-operative Salt Retention and its Relation to Increased Adrenal Cortical Function," in the *Annals of Surgery* for September, 1950. This paper was presented before the Annual Session of the American Surgical Association at Colorado Springs, Col., on April 12, 1950.

Joseph A. Johnston, M.D., Detroit, presented two papers at the annual session of the State Medical Society of Wisconsin, "The Special Problems of the Adolescent Child," and the "Factors Which Affect Growth as Measured by Nitrogen and Calcium Studies," October 4, 1950. He also conducted the Round Table on "Chronic Intestinal Indigestion."

Jerome W. Conn, M.D., Ann Arbor, presented a paper "Clinical Implications of ACTH and Cortisone" at annual session of the State Medical Society of Wisconsin, October 4, 1950.

Hermann Pinkus, M.D., Monroe, Mich.; and **John N. Grekin, M.D.,** Detroit, published an article, "Sporotri-

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WAYNE UNIVERSITY COLLEGE OF MEDICINE AND THE ALLERGY CLINIC OF DETROIT RECEIVING HOSPITAL

Present

Symposium on Modern Concepts of Allergic Diseases

Wednesday, November 29, 1950, Wayne University College of Medicine, Auditorium

Chairman, Jack Rom, M.D.

Time	*Subject*	*Speaker*
Morning Session		
9:00- 9:35	"Immunologic Aspects of Allergic Disease"—recent progress and present status	Dr. Sidney Friedlaender, Instructor in Clinical Medicine
9:40-10:10	"Pharmacologic Aspects of Allergic Diseases"	Dr. Victor A. Drill, Professor of Pharmacology
10:15-10:45	"Pathology of Allergic Disease"	Dr. Osborne A. Brines Professor of Pathology
	Intermission	
11:00-11:30	"Internal Medicine and Allergy"—recent progress, the collagen diseases, et cetera	Dr. Samuel Jacobson, Assistant Professor of Clinical Medicine
11:35-12:05	"Allergy and the Cardiovascular System"	Dr. Jack Rom, Instructor in Clinical Medicine
	Lunch	
Afternoon Session		
1:30- 2:00	"Gastrointestinal Allergy"	Dr. Homer Howes, Instructor in Clinical Medicine
2:05- 2:35	"Neurological Aspects of Allergy"	Dr. Gabriel Steiner, Professor of Neuropathology
2:40- 3:10	"Psychiatric Aspects of Allergy"	Dr. James C. Moloney, Associate Professor of Psychiatry
	Intermission	
3:25- 3:55	"Allergic Dermatoses"	Dr. Loren W. Shaffer, Professor of Dermatology
4:00- 4:30	"Ocular Allergy"	Dr. Albert D. Ruedemann, Professor of Ophthalmology
4:35- 5:05	"The Management of Allergic Problems in the Surgical Patient"	Dr. Alex S. Friedlaender, Instructor in Clinical Medicine

There will be no registration fee, but all interested in attending the sessions should write to Jack Rom, M.D., Wayne University College of Medicine, Detroit, Michigan.

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chosis with Asteroid Tissue Forms," in the *Archives of Dermatology and Syphilology,* May, 1950.

W. S. Reveno, M.D., Detroit, had a paper on "Intestinal Lipodystrophy" (Whipples Disease) published in the *New England Journal of Medicine* for August 10, 1950.

Meyer O. Cantor, M.D., and Roland P. Reynolds, M.D., Detroit, are authors of an original Article "Gelfoam and Thrombin in Gastroduodenal Bleeding" which appeared in *The Journal of Laboratory and Clinical Medicine,* June, 1950.

* * *

Recent appointments to the Wayne University College of Medicine staff:

Dr. Willard George McCullough has been assigned as Assistant Professor of Microbiology. Dr. McCullough has his Ph.D. degree from the University of Wisconsin. Dr. McCullough was formerly in the medical bacteriology department at the University of Michigan, and his fields of research have been in microbial biochemistry and microbial nutrition, studying growth requirements of the organisms occuring in brucellosis and anthrax. During World War II, he served in the Army as bacteriologist in bacterial nutrition at Camp Detrick for three years.

Dr. Harold Dwight Priddle has just been appointed as Professorial Associate in the Department of Obstetrics and Gynecology. Dr. Priddle is sponsored by a special grant from the Michigan State Department of Health. Dr. Priddle received his M.D. degree from Vanderbilt University School of Medicine, and comes to us from the Chicago Lying-in Hospital.

Dr. Marion Barnhart has been appointed Instructor in Physiology, replacing Dr. Earl Gerheim. Dr. Barnhart received her Ph.D. degree from the University of Missouri.

* * *

Senate Committee Staff Working out Questionnaire on Medical Services.—Dr. Dean A. Clark's committee is working out final details of a questionnaire designed to bring in information on health insurance plans and state and local health services. The committee was appointed by the Senate Labor and Public Welfare Committee, with instructions to report back by February 1, 1951. The questionnaire will be sent to all national health, hospital and medical care insurance companies and organizations and to a cross-section of smaller units operating in this field.

* * *

Red Cross Responsible for Nurses' Aide and First Aid Training.—Red Cross has been given two more major civil defense responsibilities. In addition to supervising the nationwide blood program, it will co-ordinate first aid courses and courses for home nursing training and nurses' aide training. It is estimated that 20,000,000 persons may eventually participate in first aid courses, and that 100,000 women may receive home nursing or nurses' aide training. Work has been completed on a

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first aid handbook, and some first aid courses have been started. Appeals to the public and health profession have been made by W. Stuart Symington, NSRB chairman, and General George C. Marshall, Red Cross director. Dr. Ross T. McIntire, director of the Red Cross blood program, made a particular appeal to the medical profession. "We look to the medical profession for strong support," he said. "This is something bigger than we have ever undertaken before. If we are to succeed, we can do so only with the wholehearted co-operation of individual physicians. Up to now we have met all demands, but there is a long pull ahead."

* * *

State "P. & A." Groups Formed for Doctor Draft.—The Government has revived, in effect, the procurement and assignment system of World War II days to pass upon availability of physicians and dentists for military service. After weeks of delay, proclamation of the doctor-draft issued from White House on October 5 and by nightfall telegrams were being sent to prospective chairmen of advisory groups in all states and territories. For some unfathomable reason, all this was kept quite secret but we can report not only that the foregoing is factual but also:

1. Each state advisory group is to be headed by a doctor of medicine and is to include a dentist, the state public health officer (or his representative) and such other members as the chairman may designate.

2. The parent agency, sitting in Washington, will be the National Advisory Committee on the Selection of Doctors (sic), Dentists and Allied Specialists which was created Wednesday by President Truman. Its chairman and membership coincide with Health Resources Advisory Committee to National Security Resources Board, Dr. Howard A. Rusk being head of both groups.

3. David M. Heyman, chairman of the board of Health Insurance Plan of Greater New York, has resigned from the NSRB advisory body, hence is not a member of the draft advisory committee. He will be replaced by a physician. Quitely and unannounced, his resignation was turned in when decision was made to have the NSRB health advisors double as draft counselors. Since Heyman was sole layman on the 8-member board, and doctor-draft law requires that all members of National Advisory Committee be professionals in health sciences, his departure was inevitable.—WRMS, Oct. 9, 1950.

* * *

Highlights of Proclamation.—First registration, taking in former ASTP's and V-12's in medicine, dentistry, and veterinary medicine who served less than twenty-one months military duty following completion of professional training, is scheduled for October 16. Doctors of osteopathy will not be required to register. Selective Service will fix registration dates for doctors of medicine, dentists and veterinarians—up to age fifty—who do not fall within the first-target bracket. The latter (class of October 16) includes not only ex-ASTP's and V-12's but also those deferred from military duty for purpose of

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continuing professional education. Governors of all states and territories are requested by President Truman to co-operate "to accomplish effective and complete registration."—WRMS, Oct. 9, 1950.

* * *

Rudolf J. Noer, M.D., Detroit, has been named Assistant Dean of Wayne University College of Medicine by the Detroit Board of Education.

Congratulations, Dr. Noer!

* * *

Poor Roads Contribute to Poor Health.—A Doctor of Medicine can't get to a patient or an ill person can't get to a doctor or a hospital, over bogged down roads.

Statement from a Texas representative at Conference on M.D. participation in Health Councils, Detroit, October 1, 1950.

* * *

Talks on Atomic Energy are available by members of the Committee on Atomic and Allied Procedures—refer requests to Chairman A. A. Humphrey, M.D., 183 West St., Battle Creek.

* * *

"Already the Hill-Burton Hospital Construction program has been cut 50% for current fiscal year, from $150 Million to $75 million."

Washington Report on the Medical Sciences, Sept. 18, 1950.

Meanwhile Social Security has been increased by millions and millions (through HR. 6000) representing in some areas of endeavor a waste of funds through overlapping of services and the extension of unimportant projects.

* * *

Fourth Clinical Session of AMA in Cleveland, December 5-8.—The Fourth Clinical Session of the American Medical Association will be held in Cleveland, December 5-8.

The scientific sessions and the scientific and technical exhibits will be presented in the Cleveland Municipal Auditorium. Meetings of the House of Delegates will be held in the Statler Hotel.

* * *

White House Conference on Children and Youth.—This meeting will be held in Washington, D. C., December 3-7, 1950. The state counterpart—the Conference on Children and Youth in Michigan—was held at East Lansing, September 14-15. Four MSMS representatives were in attendance.

* * *

No Rh Testing.—The budget of the Michigan Department of Health Laboratories was reduced at the recent session of the Michigan State Legislature. It has, therefore, become necessary to eliminate Rh testing from the list of routine services offered by the Laboratories.

* * *

You may look for the Socialists to renew their attempt to have Federal Aid to Medical Education legislation enacted early in the next session of Congress. Woven into the plot will be a "patriotic" plea of "our national

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safety is dependent on having more practicing physicians and Federal Aid to Medical Education is the solution to the problem."

This strategy was revealed by Oscar Ewing in a speech before the American Jewish Congress at New York when he said: "In a period of mobilization, when our troops are committed in Korea and when we are building an armed force of millions of men, it is more than serious (lack of doctors according to Mr. Ewing). "It is critical."—A.A.P.S. President Jos. C. Burten, M.D.

Michigan's tuberculosis records for 1949 show the number of deaths and new cases to be highest among older men, next highest among younger women.

	TB Deaths	*New TB Cases*
TOTAL	1,400	5,953
MEN Age 40-70	614 (43.8%)	1,908 (32.0%)
WOMEN Age 20-50	267 (19.0%)	1,453 (24.4%)

Children between ages 5 and 15 had only 1 per cent of the year's tuberculosis deaths and less than 4 per cent of the new cases.

Michigan Tuberculosis Association

The Society for Investigative Dermatology, at its last annual meeting, elected the following officers for the coming year:

For President: Dr. Marion B. Sulzberger, New York

For Vice President: Dr. Nelson Paul Anderson, Los Angeles

For Secretary-Treasurer: Dr. Herman Beerman, Philadelphia

For Director: Dr. Chester N. Frazier, Boston

At this meeting the Society selected Atlantic City as the place for their next annual two-day meeting in 1951.

* * *

Milton Shaw, M.D., of Lansing was honored by the citizens of Morrice, Michigan, on July 6, 1950, with a testimonial dinner on the occasion of the doctor's birthday. Friends from Detroit, Farwell, Gaines, Jackson, Lansing, Perry and Owosso, including his first school teacher, were present to do hometown honor on the occasion of Dr. Shaw's sixty-first birthday.

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The September, 1950, Muskegon County Medical Society Bulletin was a memorial issued to the late Robert J. Douglas. His photograph on the cover and a fitting eulogy were features of this Number.

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The cost of medical care (including drugs) for the year 1949 was 45 per cent higher than in the "normal" years of 1935-39, while the **cost of living was up 69 percent.**

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Included in the over-all medical figure were doctors' fees, up 38 per cent; dentists fees, up 51 per cent, prescriptions, up 37 per cent; and hospital rates, up 127 per cent—but the average stay in hospitals was shorter so that the patient's bill went up 67 per cent.—*Time*, Aug. 7, 1950.

* * *

American Academy of General Practice of Michigan: 1950-51 officers are: President: L. T. Henderson, M.D., Detroit; President Elect: E. C. Long, M.D., Detroit; and Secretary-Treasurer: Harold Raynor, M.D., Detroit.

* * *

The American Academy of General Practice of Wayne County officers are: President: John A. Maloney, M.D.; Vice President: P. C. Gittings, M.D.; Secretary: M. H. Marks, M.D.; and Treasurer: Harold F. Raynor, M.D.

* * *

The American Academy of General Practice of Wayne County held its fourth annual Postgraduate Lectures at the Rackham Memorial Building, Detroit, October 25-26. Speakers included: Gordon Bell, M.D., Toronto; Daniel Hurst, M.D., Detroit; Mr. George Hood, Detroit; Thomas J. Heldt, M.D., Detroit; Warren B. Cooksey, M.D., Detroit; Roscoe Cavell, M.D., Detroit; Herman Scarney, M.D., Detroit; Joseph Seifter, M.D., Philadelphia; E. C. VonderHeide, M.D., Detroit, Arthur Schiller, M.D., Detroit, Howard C. Walser, M.D., Detroit, Eugene A. Osius, M.D., Detroit; M. E. Bachman, M.D., Detroit; Lionel Braun, M.D., Detroit; Harold M. Rosen, M.D., Detroit; George Smith, M.D., Detroit; E. S. Gurdjian, M.D., Detroit; and Carl H. Schulte, M.D., Detroit.

* * *

The Auditorium at Wayne County General Hospital and Infirmary, Eloise, was officially dedicated the "T. K. Gruber Memorial Auditorium" on September 29, in the presence of civic industrial and union leaders of Detroit and Wayne County.

The late Dr. Gruber was a long-time member of the Michigan State Medical Society, one of the MSMS Delegates to the AMA House of Delegates at the time of his untimely death, and was Past President and Past Treasurer of the Wayne County Medical Society.

* * *

John R. Giffen, M.D., oldest practicing physician in Van Buren County, celebrated his 81st birthday September 29, 1950, as he began his 57th year of practice in Bangor, Michigan. Dr. Giffen is a member of the MSMS Fifty Year Club.

Congratulations Dr. Giffen!

* * *

Arthur B. McGraw, M.D., and H. Saul Sugar, M.D., both of Detroit, were guest speakers at the 1950 Cleveland Assembly of the International College of Surgeons, United States Chapter, under the Presidency of Custis Lee Hall, M.D., Washington, D. C., with George Curtis, M.D., of Columbus, Ohio, as General Chairman.

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(Continued on Page 1342)

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The Michigan State Board of Registration in Medicine, on September 22, gave notice that it reinstated the Michigan medical licensure of John W. Warren, M.D., on June 15, 1950.

The Second Industrial Health Day, scheduled for Wednesday, April 4, 1951, will be held in the Horace H. Rackham Educational Memorial, 60 Farnsworth, Detroit.

C. E. Umphrey, M.D., President of the Michigan State Medical Society, will be Toastmaster at the banquet to be held at the Wardell-Sheraton Hotel (one block from the Rackham Memorial Building), after the scientific program.

Dr. Lillian Gilbreth ("Cheaper by the Dozen") will be guest speaker at the banquet.

Sponsors of the Michigan Industrial Health Day are: Michigan Association of Industrial Physicians and Surgeons, the MSMS Committee on Industrial Health, the Medical School of the University of Michigan, the School of Public Health of the University of Michigan, Wayne University College of Medicine, and the Division of Industrial Health of the Michigan Health Department.

The MSMS Emergency Medical Service Committee is building a library of books and booklets and current literature on the general subject of "Civilian Defense."

Through the efforts of Committee member William Henry Gordon, M.D., Detroit, the following initial contributions have been made to the library, located in the MSMS Executive Office, 2020 Olds Tower, Lansing 8, Michigan:

1. Civilian Defense of the United States (Dupuy and Carter), published by Farrar and Rinehart, Inc., New York.
2. Civil Air Defense (Augustin M. Prestiss, Ph.D., Lt. Col. General Staff Corps, United States Army), published by Whittlesey House, London (McGraw-Hill Book Company, Inc.).
3. The Effects of Atomic Weapons, prepared for and in co-operation with the U. S. Department of Defense and the U. S. Atomic Energy Commission—under the direction of the Los Alamos Scientific Laboratory, New Mexico—published by the Superintendent of Documents, U. S. Government Printing Office ($1.25 per copy).
4. United States Civil Defense, published by the National Security Resources Board and printed by the United States Government Printing Office.
5. Nuclear Science Abstracts—from the United States Atomic Energy Commission, Vol. 4, No. 17-18 (September 15 and September 30, 1950).
6. Lecture Series in Nuclear Psychics—published by the United States Government Printing Office, Washington, D. C.

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(Continued from Page 1342)

7. List of film available through the Motion Picture Library—including those on atomic energy—American Medical Association, 535 N. Dearborn, Chicago 10, Ill.

* * *

D. H. Kaump, M.D., Detroit, was appointed by the Governor to the Technical Committee on Health and Medical Matters in Civilian Defense, upon the recommendation of MSMS President C. E. Umphrey, M.D. **L. Fernald Foster, M.D.**, Bay City, MSMS Secretary, spoke to the Bay City Kiwanis Club on September 14. His subject was "Compulsory Health Insurance"; he spoke to the Detroit Kiwanis on "American Medicine" on September 19; to the Grosse Pointe Rotary Club on "Medical Care—The American Way," September 18.

* * *

The 7th Councilor District, under the leadership of H. B. Zemmer, M.D., Lapeer, held a meeting in American Legion Hall, Lapeer, on October 31. An address on "Atomic Energy and its Relationship to Medicine" was given.

The program was arranged by the MSMS Committee on Atomic and Allied Procedures of which A. A. Humphrey, M.D., Battle Creek, is Chairman.

* * *

Public health service grants in the number of 155, totaling $4,708,766, recently were announced by Surgeon General Leonard A. Scheele, including the following in Michigan: University of Michigan, Ann Arbor—John D. Adcock, M.D., $9,396; John W. Bean, M.D., $3,000; William Dodd Robinson, M.D., $39,656; Raymond L. Garner, $4,104; H. Marvin Pollard, M.D., $1,100; Jerome W. Conn, M.D., $18,144; Felix G. Gustafson, $3,240; M. H. Seevers, M.D., $15,228. Wayne University, Detroit—Harry C. Saltzstein, M.D., and David J. Sandweiss, M.D., $11,138; Fred L. Rights, $3,800; W. W. Zuelzer, M.D., $7,000; F. Gaynor Evans, $6,100; Ernest D. Gardner, M.D., $12,000; and Walter H. Seegers, $12,862.

* * *

The 30th Annual Michigan Public Health Conference will be held at the Pantlind Hotel, Grand Rapids, November 29-30-December 1, 1950. General sessions will be held in the Black and Silver Ballroom of the Civic Auditorium under the Presidency of George C. Stucky, M.D., Charlotte.

Speakers include Michigan Health Commissioner A. E. Heustis, M.D., Lansing, Jerome Conn, M.D., Ann Arbor; F. S. Leeder, M.D., Lansing; Franklin H. Top, M.D., Minneapolis, and Haven Emerson, M.D., New York City.

Thursday, November 30, will be devoted to Section Meetings for Public Health Medical Directors, Dentists, Public Health Nurses, Engineers and Sanitarians, Nutritionists, Health Department clerical personnel and dental hygienists.

Friday, December 1, will be devoted to a seminar on "Meeting Health Problems in Disaster."

All members of the Michigan State Medical Society are cordially invited to attend. For detailed program write Dr. Stucky at Eaton County Health Department, Charlotte.

J. S. DeTar, M.D., Milan, a member of The Council of the Michigan State Medical Society, addressed the B'nai Brith Lodge in Congregation B'nai Israel Auditorium, Pontiac, on October 8, at a public meeting on "The Medical Profession's Answer to Socialized Medicine." Dr. DeTar was introduced by O. O. Beck, M.D., Birmingham, President Elect of the Michigan State Medical Society.

* * *

O. A. Brines, M.D., Detroit, has been named Chief Consulting Pathologist to the Veterans Administration. As such, Dr. Brines becomes a member of a twenty-four member national board representative of every branch of medicine, which board is the highest medical advisory board to the Veterans Administration. James H. Maxwell, M.D., of Ann Arbor is the other board member from Michigan.

* * *

Fifty per cent of lymphosarcomas are in the tonsil.

* * *

One of the most reliable clinical methods of determining whether or not a neck tumor has arisen in the thyroid is to observe the act of swallowing. If the tumor moves upward and downward, it is almost certainly a thyroid growth.

* * *

If a thyroid tumor is unusually hard and irregular in outline, it is probably cancer.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

AN ATLAS OF HUMAN ANATOMY. By Barry J. Anson, Ph.D., Professor of Anatomy, Northwestern University Medical School. Philadelphia: W. B. Saunders Co. Price $11.50.

Dr. Anson has given us a completely new book, based on new dissections and covering the whole body. These are made with especial reference to a teaching value, but the use by the surgeon is prominently kept in mind. We have never seen more clear or useful illustrations. They are profuse, every vein, nerve, artery, bone, muscle or other structure is plainly marked, with a lead line, and the name is in Latin, so any student will be able to use the book even if he should not be able to read English. This is an Atlas, not a textbook with all the details and fine print. The pictures are large, easily seen and studied, and would make an excellent surgical reference book. No surgical operations are given, but some dissections and parts are turned back to give a better view of structure and relations. We like the book immensely.

THE ANTIHISTAMINES. Their Clinical Application. By Samuel M. Feinberg, M.D., Associate Professor of Medicine, Chief of Division of Allergy and Director of Allergy Research Laboratory; Saul Malkiel, Ph.D., M.D., Assistant Professor of Medicine, Director of Research Allergy Research Laboratory; Alan R. Feinberg, M.D., Clinical Assistant in Medicine, Attending Physician in Allergy Clinic. Northwestern University Medical School. Chicago: Year Book Publishers, Inc. Price $4.00.

The universal use of antihistamines for colds and allergies makes this book especially timely. The structure and formation of these drugs is given in the chapter on chemistry. Later most of the antihistamines on the market are described and their action stated, with studies of the percentage and type of side reactions. There is a real need for a book of this type which can be used as a ready reference.

INFECTION AND SEPSIS IN INDUSTRIAL WOUNDS OF THE HAND. A Bacteriological Study of Aetiology and Prophylaxis. By R. E. O. Williams and A. A. Miles (assisted by Barbara Clayton-Cooper and Brenda Moss). Privy Council Medical Research Council Special Report Series No. 266. London: His Majesty's Stationery Office, 1949. Price is 6d. Net.

This is a small paper-bound volume giving the results of a very thorough study of wound infection, chiefly as it applies to industry. The general conclusion appears to be that most of the infections are due to pre-existing organisms on the skin, and that the most frequent offender is staphylococcus aureus. Treatment and prophylaxis are discussed. The brochure is not quite current, as far as antibiotic therapy is concerned.—A.A.H.

DOCTOR COME QUICKLY. By Frank J. Clancy, M.D. Seattle: Superior Publishing Company, 1950. Price $2.95.

The author is a practicing physician in Seattle and has told his own story very interestingly and quite fully. He tells of his efforts to get into medical school, his trials, his graduation and of the especially difficult time getting started in practice during the years when a practice was not waiting for the young man to hang out his shingle, but when he had to struggle for every patient, and how he was glad to take the destitute, the surplus from other doctors, and the intense competition between doctors. He

tells very interestingly of the interesting cases he and a friend worked up, of his learning the hard way to examine a bladder by the cystoscope, and of his finally gaining recognition by careful and persistent work. He followed the trend of the times and made a trip to Vienna where he attended lectures. He tells of the AMA of Vienna, and its method of assigning patients and students to certain clinics or teachers. A very entertaining personal history.

THE TRUTH ABOUT YOUR EYES. By Derrick Vail, M.D. New York: Farrar, Strauss and Company, 1950. Price $2.50.

Many times the ophthalmologist has a patient with a particularly distressing more or less chronic condition which he describes and explains, repeatedly, only to have to repeat frequently. Dr. Vail has prepared a little book for the layman telling about the eye and its more prominent diseases or disabilities in terms the layman can understand. Dr. Vail is abundantly prepared and able to offer this book, and we believe it will be freely used as an adjunct to treatment. The book gives especially valuable chapters on glaucoma, cataract, refraction, muscle disturbances, injuries and eye hygiene. Well done.

SIGNIFICANCE OF THE BODY FLUIDS IN CLINICAL MEDICINE. By L. H. Newburgh, M.D., Professor of Clinical Investigation, University of Michigan Medical School, Ann Arbor, Michigan. Assisted by Alexander Leaf, M.D., Instructor in Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan. Springfield: Charles J. Thomas Publisher. Price $2.00.

The authors are Michigan men who were asked to give a series of lectures in Portland, Oregon, as the "Ernest A. Sommer Memorial Lectures," to cover some advance in physiology or pathology. This book on the body fluids was the result. The physiology of the body fluids is given, their composition, the elements which make up their structure, their atomic or molecular structure and weights, and their functions are carefully and clearly stated in a manner understandable by the medical practitioner. About sixty per cent of the book is devoted to the clinical significance of these fluids, their variations, and application of our knowledge of them. This is a very useful book, bound in a black semi-stiff cover, well printed in very legible type.

HARVARD SCHOOL OF PUBLIC HEALTH. Annual Report of the Dean, 1948-49. Cambridge: Published by the University, 1950.

This is quite a complete report of the work of the school, showing progress in teaching public health. A historical sketch is followed by the listing of the staff, discussions of the teaching problems and fields, and a fairly complete outline of the work done during the year.

VOCATIONAL REHABILITATION OF PSYCHIATRIC PATIENTS. By Thomas A. C. Rennie, M.D., Cornell University Medical College and the New York Hospital; Temple Burling, M.D., and Luther E. Woodward, Ph.D., Division of Rehabilitation, The National Committee for Mental Hygiene. New York: The Commonwealth Fund, 1950. Price $0.75.

The patient who has been given full advantages of rehabilitation treatment still has a problem all too frequently neglected. He has no job awaiting, and no experience in getting a job. This feature of the problem is considered in the first chapter. Surveys of convalescent patients in Traverse City State Hospital, Pontiac State Hospital, Ypsilanti State Hospital and Wayne County Hos-

pital give interesting facts. Comparison of rehabilitation work done in Connecticut, New York and Michigan on Psychosis, Psychoneurosis, Psychotic personality, Mental Deficiency, Epilepsy, Nervousness and other mental and nervous diseases for 1947 and 1948 totaled more for Michigan than for both of the other states. There are chapters on job finding and placement, adaptation of rehabilitation to rural areas, with considerable case work problems. A paper-covered handbook.

SURGERY OF CATARACT. By Daniel B. Kirby, A.M., M.D., LL.D. Professor of Ophthalmology (former Chairman of the Department), College of Medicine, New York. University; Attending Surgeon (former Director), Department of Ophthalmology, Bellevue Hospital; Surgeon, New York Eye & Ear Infirmary; Consulting Ophthalmic Surgeon, Manhattan Eye, Ear & Throat Hospital, St. Clare's Hospital, Department of Ophthalmology, and New Rochelle Hospital, Department of Ophthalmology; Former Associate in Ophthalmology, College of Physicians and Surgeons, Columbia University; Former Attending Surgeon, Institute of Ophthalmology, Presbyterian Hospital in the City of New York; and Fellow, the American College of Surgeons and The Pan-American Association of Ophthalmology. 339 Illustrations, including 52 subjects on 21 Color Plates. Philadelphia: J. B. Lippencott Co. Price $30.00.

Dr. Kirby and the publishers of this book have produced one of the finest examples of the printer's art, together with a most complete and satisfying text on the surgery of cataract. The history of the condition and its treatment during the ages, with the development of the various forms of cataract operation is beautifully done. Anatomy, physiology, development of the disease of cataract are all fully given, the brief but complete descriptions of the operations of the masters who have given us the profession of ophthalmology, a profusion of illustrations, Dr. Kirby says that now when we know so much about how to operate with but very little danger, and can make a complete extraction within the capsule, there is no need for patients to have a long period of near blindness. Soon after the eye has passed its useful stage it may be operated, and the sum total of results is really remarkably good. Most patients get excellent results and those who do not are so pleased with what they have received that they are happy. The book is especially timely in its discussions of complications. The active ophthalmologist cannot afford not to have it.

SURGICAL NURSING. By Eldridge L. Eliason, A.B., M.D., Sc.D., F.A.C.S. Emeritus John Rhea Barton, Professor of Surgery, University of Pennsylvania School of Medicine; Emeritus Professor of Surgery, University of Pennsylvania Graduate School of Medicine; Consulting Surgeon, Hospital of the University of Pennsylvania, Presbyterian and Philadelphia General Hospital. L. Kraeer Ferguson, A.B., M.D., F.A.C.S. Professor of Surgery, Graduate School of Medicine of the University of Pennsylvania and Woman's Medical College of Pennsylvania; Surgeon, Graduate Hospital of the University of Pennsylvania, Hospital of the Woman's Medical College of Pennsylvania, Philadelphia General Hospital and Doctors Hospital; Consulting Surgeon, Frankford Hospital and U. S. Naval Hospital, Philadelphia; Lillian A Sholtis, R.N., B.S., M.S., Assistant Professor of Surgical Nursing, Yale University School of Nursing; formerly Supervisor of Operating Rooms, Hospital of the University of Pennsylvania. Ninth Edition Revised and Reset, 336 Illustrations, Including 9 Subjects in Full Color. Philadelphia: J. B. Lippincott Co., Price $4.00.

A good work to supply training for the surgical nursing field. We commend it.

THE MERCK MANUAL OF DIAGNOSIS AND THERAPY. A Source of Ready Reference for the Physician. Eighth Edition. Rahway, N. J.: Merck & Co., Inc. 1950. Price $4.50; Thumb Index, $5.00.

The eighth edition of Merck's Manual is now available, and for a pocket size book it is a major accomplishment. Well printed on nontransparent paper, it contains almost 1,600 pages of concise, classified information. Part I, diseases and major symptoms, covers 338

chapters of symptoms, prognosis, diagnosis, Laboratory findings and treatment. No pains have been spared to make the book exact and complete. Part II is new routine on clinical and bedside procedures. Many prescriptions well given using the U. S. Pharmacopoeia and National Formulas preparations. A very compact and handy volume.

THE GENEALOGY OF GYNAECOLOGY. History of the Development of Gynaecology throughout the Ages. 2000 B.C.—188 A.D. With Excerpts from the Many Authors who have Contributed to the Various Phases of the Subject. By James V. Ricci, A.B., M.D. Clinical Professor of Gynaecology and Obstetrics, New York Medical College; Director of Gynaecology, City Hospital, New York; Attending Gynaecologist and Obstetrician, Flower and Fifth Avenue Hospitals; Consultant in Gynaecology and Obstetrics, Beekman-Downtown Hospital; Consultant in Gynaecology and Obstetrics, Columbus Hospital; Fellow of the New York Academy of Medicine; Honorary Member of the Italian Society of Medical History and the Natural Sciences. Department of Gynaecology and Obstetrics New York Medical College City Hospital Division. Second edition, enlarged and revised. Philadelphia: The Blakiston Co., 1950. Price $8.50.

A second edition of this valuable historial volume gives the author opportunity to revise and re-evaluate his material and to add much that has been developed by later research.

The well-informed gynecologist should be well served by this volume as a review and a stimulus to greater effort. Any research library or historical collector needs it.

TAX DOLLARS

A lot of people—since the Korean War started—have been wondering aloud about where their tax dollars have been going. A recent issue of *Barron's*, a financial weekly, carried an article that says the United States pays 100,000 employes more than $270 million a year just to store and issue supplies. *Barron's* finds no particular fault with this, but appears to be somewhat concerned that one agency has on hand enough fluorescent bulbs to last 93 years! Another agency has enough ruled paper to last till the year 2118, and a third has enough loose leaf binders to get through the year 2197! And—no joke or pun intended—the Hoover Commission found many agencies had a fifty-year supply of red tape.

GROWTH THROUGH CO-OPERATION

(Continued from Page 1320)

health organizations and the people of the state of Michigan.

While the Council is designed and operated as a fast-moving vehicle, it still remains sufficiently flexible to meet current demands, for example, in its participation in the Michigan Civil Defense program and in the dissemination of authentic information from the newly created committee on Atomic and Allied Procedures of the Michigan State Medical Society.

Within a period of 18 months, the idea which the Michigan State Medical Society germinated has been transformed into an aggressive, positive, vigorous program the blueprints of which have been sought by 22 states; the structure and activity of the Michigan Health Council have been cited by the American Medical Association and the National Health Council.

New horizons have been sighted and an indelible trail has been left behind by the aggressive, expanded activities program of the Michigan Health Council—a trail which has brought recognition to the Michigan State Medical Society and the other organizations which launched the Council on its expanded program in February, 1949.

But the job is not finished. The Michigan Health Council holds fast to the philosophy expanded upon in Community Health Council organizational meetings—"the pursuit of good health is a continuing program."

MILITARY MEDICINE

Who Is In the Reserves?

(Continued from Page 1260)

and the Bureau of Naval Personnel have supplied the following information, which should be considered only for guidance, not for determination of status:

Army:

"Reserve officer appointments or reappointments in force at the outbreak of World War II (or made subsequently) remain in force until six months after termination of the war or termination of the five-year appointment period, whichever is the later, unless specific action to terminate the appointment has been taken by the Department of the Army. Under current law in this instance, World War II has not been declared terminated."

Navy:

"A man is still in the Naval reserves unless: (1) he has resigned his reserve commission, or (2) he has been discharged from the reserves. The mere release to inactive duty of an officer in the Naval Reserves does not sever his connection with the Navy."

Air Force had no separate medical service during World War II. The Air Surgeon's office said that its situation would be covered by the above Army statement.

We repeat, the proper course is for every man uncertain of his reserve status to contact his Military District commanding officer or Naval District commandant.

Classified Advertising

$2.50 per insertion of fifty words or less, with an additional five cents per word in excess of fifty

FOR SALE: Well-established practice of competent physician and surgeon who recently died. Location: Saginaw, Michigan. Population over 90,000. Write Administrator, Clarence A. McGee, 1688 Brockway, Saginaw, Michigan.

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FOR SALE: Former physician's residence, ideally adapted for general practice in small mid-western Michigan town located in prosperous farming and fruit area. Hospital facilities in Grand Rapids and Muskegon. Grade school with high school bus facilities. Immediate occupancy of oil heated, seven-room one-story brick house with attached three-room office and garage. Contact: Mrs. A. E. Fleming, 1025 Audubon Road, Grosse Pointe Park 30, Michigan.